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MEDICARE AT RISK: EMERGING FRAUD IN MEDICARE PROGRAMS

HEARING

BEFORE THE

PERMANENT
SUBCOMMITTEE ON INVESTIGATIONS
OF THE

COMMITTEE ON
GOVERNMENTAL AFFAIRS
UNITED STATES SENATE

ONE HUNDRED FIFTH CONGRESS

FIRST SESSION

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MEDICARE AT RISK: EMERGING FRAUD IN MEDICARE PROGRAMS

THURSDAY, JUNE 26, 1997

U.S. SENATE,
PERMANENT SUBCOMMITTEE ON INVESTIGATIONS,
OF THE COMMITTEE ON GOVERNMENTAL AFFAIRS,
Washington, DC.

The Subcommittee met, pursuant to notice, at 9:03 a.m., in room SD–342, Dirksen Senate Office Building, Hon. Susan M. Collins, Chairwoman of the Subcommittee, presiding.

Present: Senators Collins, Glenn and Durbin.

Staff Present: Timothy J. Shea, Chief Counsel and Staff Director; Mary D. Robertson, Chief Clerk; Ian T. Simmons, Counsel; Rena M. Johnson, Counsel; Don Mullinax, Investigator, John Frazzini, HHS–IG Detailee; Lindsey Ledwin, Staff Assistant; Andrew MacDonald, Intern; Jeffrey S. Robbins, Minority Chief Counsel, and Rachael Sullivan, Staff Assistant.

Other Staff Present: Andrew Weiss (Senator Thompson); Anne Rehfuss (Senator Cochran); Len Weiss (Senator Glenn); Gale Perkins (Senator Levin); Chris Stanek, Marianne Upton, and Rebecca Yee (Senator Durbin); and Kevin Franks (Senator Cleland).

OPENING STATEMENT OF SENATOR COLLINS

Senator COLLINS. The Subcommittee will please come to order.

Good morning. This is the first hearing in the 105th Congress of the Permanent Subcommittee on Investigations and the first hearing that I have called since being appointed Chairwoman earlier this year. Let me say at the outset that it is an honor and a privilege to serve as Chairwoman of this Subcommittee—a panel with a long and distinguished history.

PSI was first authorized by the Senate almost 50 years ago, in January of 1948. It was established as a permanent Senate Subcommittee as a result of the work of the famous "Truman Committee." During World War II, then-Senator Truman used this Subcommittee to ferret out waste, fraud and abuse in the National Defense Program.

Continuing this tradition, PSI has exposed problems in numerous government activities, including military procurement, health and welfare programs and Federal student aid programs. Exposing and eliminating waste, fraud and abuse will continue to be the Subcommittee's priority during the 105th Congress.

The American people deserve honest and effective government. By shining a spotlight on mismanaged programs, corrupt practices

and wasteful policies, PSI can help prevent the theft and misuse of taxpayers' hard-earned money.

This morning, we launch a new health care initiative focusing first on the Medicare program. Medicare reaches virtually every American family. Approximately 38 million older Americans are enrolled in this program, which costs taxpayers almost $200 billion each year. In fact, about 14 percent of all Americans receive health care services from Medicare. In my home State of Maine, the percentage is even higher—approximately 17 percent of the State population was enrolled in Medicare in 1995.

As the baby boomer generation reaches retirement age, the cost of and the population served by Medicare will only explode. It is appropriate, therefore, that PSI begins its work in the 105th Congress with an investigation of this critical health care program.

Today's hearing is the beginning of a new effort to expose emerging fraud and abuse in Medicare, with the twin goals of protecting the taxpayer from unscrupulous individuals who steal literally billions of dollars from Medicare and of protecting elderly and disabled Americans who rely on this important program for their health care needs.

As the General Accounting Office, from which we will hear later today, has repeatedly warned, Medicare is a high-risk program, especially vulnerable to waste, fraud, abuse and mismanagement. According to several reports and audits, between 5 and 10 percent of Medicare spending is lost each year to waste, fraud and abuse.

In a program funded at about $200 billion, that means between $10 billion and $20 billion is bilked each year from Medicare. And even that startling estimate may actually be too low. We have seen recent newspaper reports that an unpublished audit by the Department of Health and Human Services indicates that the amount of improper payment is much higher than previously thought. HHS told our staff during a closed briefing that the unpublished audit indicates that an estimated 14 percent of Medicare spending is the result of improper payments. That amounts to an astronomical $23 billion. And, even more troubling, that is only the mid-range estimate. HHS told the Subcommittee that the high range was 17 percent, or $27 billion annually, in improper payments.

Unfortunately, as those of us who have recently been through the debate on the budget know, there is no line item in the budget entitled, "Medicare Waste, Fraud and Abuse" that we can simply strike to eliminate this problem. The task of ferreting out wasteful and fraudulent spending is a difficult one made more complicated by the ingenuity of scam artists, coupled with our limited enforcement resources.

The Subcommittee's preliminary review indicates that no part of Medicare is immune from waste, fraud and abuse. There are far too many instances of fraud and wasteful spending in home health care, for example, leaving the elderly with inferior or nonexistent services as unscrupulous providers get rich picking the taxpayers' pockets.

Home health care is designed to give the elderly the opportunity to receive health care at home instead of in a hospital or a nursing home. It is a compassionate and preferred alternative for many elderly Americans, and it makes good fiscal sense as well. But far

too often, this wonderful idea is abused by unscrupulous health care bandits who abuse the home health care program to raid the Federal Treasury and to steal billions through improper billings.

Let me just give you a couple of examples of the audacious schemes to defraud Medicare. For example, one Florida home health care agency billed Medicare for $84,000 for gourmet popcorn, $140,000 for an airplane, $14,000 in company logo emery boards, and $5,000 to lease a BMW for the owner's son. In another case, the chief executive officer of ABC Home Health Services, Inc., one of the Nation's largest home health care chains, was convicted of billing Medicare for more than $14 million in false expenses, including jewelry and a luxury beach house.

Similar fraud can occur in the nursing home setting as well, where unscrupulous providers have access to patients who each have valuable Medicare beneficiary numbers. These numbers are as good as gold and can be used to fraudulently bill Medicare. Individuals with access to these numbers can open the floodgates for Medicare payments, illegally draining the Treasury of billions of dollars each year.

Fraud in the nursing home setting, as you will hear today, can take several forms. Some simply charge for services never rendered or equipment not provided. Others charge Medicare for expensive medical equipment while providing the elderly with inferior products. This fraud not only shortchanges the taxpayer, but it also hurts our most vulnerable senior citizens, who are not given quality services and equipment paid for by Medicare.

Today's hearing will also examine the problem of up-coding, fraud in the durable medical equipment industry, marketing abuses in the HMO sector, and the adequacy of current civil and criminal enforcement measures. I realize that is a very tall order to explore all of these issues, but the intent of this hearing is to be an overview hearing which will establish a framework for the Subcommittee's ongoing investigation into the Medicare program.

The Subcommittee is very pleased to first hear this morning from our Senate colleagues. We are going to begin with Senator Grassley, the Chairman of the Special Select Committee on Aging who, as I understand it, will be submitting a new GAO report on durable medical equipment; as well as from Senator Harkin, who has a longstanding interest and expertise in this area.

We will then hear from a panel of law enforcement witnesses as well as a final panel that will give the Subcommittee an overall assessment of the fraud problem in the administration of the Medicare program.

This hearing is the Subcommittee's first step in shedding light on Medicare fraud, an epidemic that poses a serious risk to the program's fiscal integrity. I am determined to investigate and expose fraud and abuse in this critical program, and I am confident that our investigation will help lay the groundwork for legislative and administrative reforms. Our senior citizens, and indeed all taxpayers, deserve no less.

Finally, let me emphasize one important and perhaps obvious point. The vast majority of health care professionals are caring, dedicated providers whose top priority is the welfare of their patients. They, too, are appalled at the unscrupulous providers who

take advantage of weaknesses in Medicare to bleed billions of dollars from the program.

I look forward to working on this important investigation with the Ranking Minority Member of this Subcommittee, who is also the Ranking Member and former Chairman of the full Committee, the distinguished Senator from Ohio, John Glenn. Senator Glenn has had a long history of working very hard to improve the efficiency of all government programs and to eliminate waste, fraud and abuse in Federal programs and services.

It is now my distinct honor to recognize Senator Glenn for any statement that he may wish to make at this time.

OPENING STATEMENT OF SENATOR GLENN

Senator GLENN. Thank you very much, Madam Chairwoman. I want to commend you and your staff for the fine job you have done in organizing this overview hearing.

We want to apologize not only to the audience that was here yesterday, or was planning to be here yesterday, and to our witnesses because we got caught in a marathon voting session yesterday, and it just did not work out that we could have a hearing at the same time. We may get into some of the same problems today. The last word I had was that we might even be starting votes as early as 9:40 this morning—I have not yet heard.

Senator COLLINS. That may be the case.

Senator GLENN. So we may have to be shuffling back and forth to keep the hearing going today.

As you say, we have had a long history on this Committee, going way, way back, and even in the time I have been on the Committee, we have focused on health care and health care problems dating back to 1981, so the Committee does not come at this as a complete novice.

We have pointed out ways in which unscrupulous health care providers and institutions have bilked the Medicare system to the detriment of patients or taxpayers, or both at the same time, and reports of this Subcommittee following those hearings have over the past 16 years contained recommendations for both the Executive and Legislative Branches on how fraud and abuse afflicting our health care systems could be deterred, detected, or targeted for prosecution.

Some of those recommendations have been taken. One of our witnesses this morning, Ms. Bucy, points out in her written statement that some of the recommendations that we have made have been taken, and some have not yet been adopted for reasons that are not always clear. What is clear is that in the case of Medicare fraud, Chairwoman Collins has not overstated matters in calling this hearing "Medicare at Risk." I think it is that serious.

We have now reached a point where of the approximately $200 billion paid out last year under Medicare, approximately $25 billion—I think your figures were $27 billion, but it is in the same general area—$25 billion to $27 billion of taxpayer money was washed down the drain—or, to pick a more precise metaphor, was diverted into the wallets of Medicare system participants guilty of fraud and abuse.

According to a recent report of *The Wall Street Journal* about an internal audit at HHS, the best evidence is that not 5 percent or 10 percent, but now up to 12 percent of all Medicare dollars are lost to fraud and abuse. The Chairwoman mentioned the high-risk list. That originated in this Subcommittee, the request for GAO and the administration to get together and set up a list of those areas in our government expenditures that are at the highest risk of fraud, abuse and mismanagement. And this is certainly on that list, and those are brought up-to-date for every Congress, and there are about 10 pamphlets that GAO has put out that are very, very good. This is one of the areas that has continually been on the high-risk list, and we just cannot continue that way.

In the face of the evidence that the problem of Medicare fraud is worsening and not improving, it is not enough to say, as one HCFA was quoted as saying just 2 weeks ago, that the Federal Government is making good progress in the battle against Medicare fraud, because the best evidence is that we are not. And I do not single out the Executive Branch to the exclusion of Congress. Clearly, there is enough blame to go around.

It is an enormous problem. We have some 822 million claims filed with Medicare each year. There are about 34 million Americans on Medicare and I think that figures out very roughly to about a claim from each Medicare recipient every 2½ weeks. That is an enormous job just to keep up with that, and I think included in that are individual prescriptions, so if somebody has a prescription filled ever 2 or 3 weeks, that would be one claim, so maybe it is not quite as big as it would appear at first blush. But it is an enormous job, and only a fraction of these claims are being subjected to any kind of meaningful review to determine if services were in fact provided as represented or provided in a way that was appropriate.

It surprises no one that the Medicare program is on that high-risk list I mentioned a moment ago as being "highly vulnerable to waste, fraud, abuse and mismanagement."

No wonder, where the review is so inadequate, the risk of being caught and punished so negligible, that as the administrator of HCFA recently told a House Subcommittee, fully one-fourth of home health claims may be spurious. That is, as many as one-fourth of home health claims may be spurious.

No wonder, when so little meaningful scrutiny is given to nursing home treatment and billing practices, the GAO recently found that fraudulent and abusive billing practices, such as billing Medicare for unnecessary or undelivered services or misrepresenting services to obtain reimbursement, are "frequent and widespread," to use their words.

It is no wonder that the Inspector General admitted in September of 1996 that the durable medical equipment, or DME, industry, another section of the Medicare system we are going to speak about today, "has consistently suffered from waves of fraudulent schemes in which Medicare is billed for equipment never delivered, totally unnecessary equipment or supplies, or equipment delivered in a different State than billed in order to obtain higher reimbursement."

Put simply, despite the fact that we have known about this problem for a long time, the Federal Government continues to do a poor job of protecting our elderly citizens and the American taxpayers from those who fraud and abuse the Medicare system.

This hearing, initiated by the Permanent Subcommittee on Investigations and the Chairwoman, is an extremely important and timely tool for pressing the Federal Government into the kind of intelligent and focused attack on Medicare fraud that has been too slow in coming. I know we will be able to point out many instances of fraud and abuse that should never occur.

I am also interested in these hearings, though, to find out what we can do about it, and for our witnesses and anyone who wants to contact the Subcommittee, to give us a better handle on this. Can we use whistleblowers, since we cannot get in and inspect everything that happens with every claim; people who see a lot of fraud within the system themselves and people who do not want to see taxpayers' dollars wasted can be of valuable help to the Committee in pointing out some of these things for us.

Should we get into asset forfeiture as we have done with some of the drug cases, and seize property, and can we put some of that asset forfeiture money back into more investigation to cut out more fraud, things like that? Can we contract outside and allow outside contractors to go in and find some of this fraud and abuse? Can we expand the role of the IG? The IGs have been a real success story. That is another one that was started by this Committee. As a result of the expansion a few years ago, we now have IGs in 61 different agencies and departments of government, doing a good job. Can we expand the IG role internally to find some of these things?

I think these are some of the things that we would like to have in addition to pointing out all the horror stories that I am sure we are going to hear.

Madam Chairwoman, that is a little longer statement than I had planned to make, but thank you very much.

Senator COLLINS. Thank you very much.

I am delighted that our first panel of witnesses, our colleagues Senator Grassley and Senator Harkin, could rearrange their schedules in view of the postponement yesterday; I know that it is a sign of your deep commitment and interest in this area, and we look forward to taking advantage of your expertise.

Senator Grassley, if you will proceed.

TESTIMONY OF HON. CHARLES E. GRASSLEY,[1] A U.S. SENATOR FROM THE STATE OF IOWA, AND CHAIRMAN, SENATE SPECIAL COMMITTEE ON AGING

Senator GRASSLEY. Senator Harkin and I do not claim that you have to be from Iowa to know about health care fraud, but——

Senator COLLINS. It helps.

Senator GLENN. It does not hurt.

Senator GRASSLEY [continuing]. He has been active in it a very long time—not active in fraud, but active in ferreting out fraud—and I appreciate very much being invited to testify as Chairman

[1] The prepared statement of Senator Grassley appears on page 61.

of the Special Committee on Aging and appreciate your membership on that Committee as well, Senator Collins.

Thank you for holding this hearing and, more importantly, using this very important Subcommittee, which has the name of "Permanent Subcommittee on Investigations," but I call it the "Subcommittee on Good Government" because of its decades of history of keeping government responsible and making sure we get our taxpayers' dollars' worth. And the fight that you are launching today is going to continue in that tradition, I know.

I also apologize that after my short statement, I have another engagement, so I would beg to answer questions in writing if you have any questions that you want to follow up on with me.

Fraud, waste and abuse are, of course, enemies of our health care system. It is a disease that is taking health care services from our children, our spouses and our elderly parents, but most importantly, it is going to deprive future generations of the social safety net that we have had for our seniors if we do not do something about it very quickly. It is costing us unnecessary millions of dollars, money that could and should be put to better use.

As Chairwoman of the Special Committee on Aging, it is a pleasure to bring to your attention the findings of a General Accounting Office (GAO) report [1] that you have already referred to that was released to me just a few days ago. This is a report regarding the prices that we taxpayers pay for medical equipment and supplies, as well as the fact that Medicare often overpays large-volume suppliers—just exactly the type of people you would think we would not be overpaying if they were doing that much business with the government and could get the special rates.

In 1996, the Medicare system paid out about $4.3 billion for medical equipment and supplies used in 1996—that is $4.3 billion. I brought a few examples of the medical equipment and supplies, and you know, there are thousands of these items, but we have brought a walker, we have catheters, we have glucose strips.[2]

What the GAO had to say in its most recent report, of course, is alarming and troubling to all of us. Specifically, the GAO said that the Health Care Financing Administration, which we know as HCFA, does not know specifically—now, get this—does not know specifically what products it is paying for when it pays for medical equipment and supplies.

Could you ever imagine paying someone for supplies that they are delivering to your patients, clients or agents, and not knowing exactly what you are paying for? If that were a private business, I would presume you would not be in business for a very long period of time.

It is interesting. This situation reminds me of the unmatched disbursements of the Department of Defense, which you have heard me talk about for the last several months on the floor of the Senate, where the Department of Defense does not want to do accounting work as a transaction occurs, like other businesses do.

Of course, the very next question one would ask after learning that HCFA does not know exactly what medical equipment or sup-

[1] Exhibit No. 1 appears on page 169 in the Appendix.
[2] Exhibit No. 2 appears on page 179 in the Appendix.

plies it pays for is, Why doesn't it know that? The reason is that HCFA does not require suppliers to identify specific products on their Medicare claims. Instead, suppliers use HCFA billing codes that usually cover a broad range of products of different types, quality, and market prices. Because Medicare pays suppliers the same amount for all the products covered by a single billing code, the supplier has a financial incentive to provide the cheapest product covered by that billing code.

Perhaps an example would be helpful, and that is why I have three different types of catheters with me as an example. For the long-term one, you have a price of $17.90; for a medium-term one, a price of $5.19; and for the short-term, a price of $1.09.

Well, let us say that I am a supplier of these catheters, and I have a catheter that costs $1, and I have some that go all the way up to $17. But what does HCFA pay? Well, as you can see there, it pays between $9.95 and $11.70, so about $10 is what they pay under that billing code that covers all catheters. So that if you are a supplier, you are crazy to supply the expensive catheters when you could supply the cheaper ones, and it means a great deal if you are a supplier. But what a bad deal it is if you are one of the millions of taxpayers who pays into the Medicare system, and you are getting the cheap one, and you are paying for at least the medium price one or even more than that, as an example.

This example of the catheters demonstrates vividly to me that the $4.3 million that we are spending annually for medical equipment and supplies is higher than it need be. It also tells me, like it or not, that we have a payment system here that is "just plain broke."

I would like to shift for a moment to what can we do about something like this, that is "just plain broke." We all as legislators, as parents, as taxpayers, have a responsibility and a commitment and a duty toward improving this situation.

In its report, the GAO said that the billing code system that HCFA uses provides insufficient information for properly identifying and paying for products billed to Medicare, and this need not be the case. It is very simple.

The Department of Defense, for example, and some health care purchasing groups are beginning to require their suppliers to use product-specific codes called universal product numbers, not different from what you find on your grocery supplies that you buy at the supermarket. Here is an example, just use the specific ones, like on this glucose box.

These universal product numbers identify the individual product. In this manner, you get what you pay for, plain and simple—not you pay for what you do not get.

I say that HCFA should be required to do the same, and in that vein, I will introduce legislation that I hope Senator Collins and the other Senators here today will join me in introducing, to ensure that HCFA immediately begins an intensive effort to initiate universal billing codes for medical equipment and supplies that are billed to the Medicare program.

In this way, we will dramatically improve the system. Then we can redirect those savings to other areas in need of attention.

In closing, I would be remiss if I did not say that citizens have an involvement in this as well, maybe following on what Senator Glenn said. We want to get people to be a part of this system; we want the average citizen to see himself or herself as a policeman of this system or even as a prosecutor of this system. So I would bring to your attention some legislation that I got passed 10 years ago for the False Claims Act. Qui tam was passed because of the problems in the Department of Defense, but it is now being used more in health care than any place else, and I would ask that in this legal, whistleblower-type action, where a citizen can file a civil claim on behalf of himself or herself and the government for violation of a statute that provides a specific penalty for wrongdoing. If the case works out, the individual may keep part of any resulting penalties.

So I thank you for this opportunity to bring this GAO report and the coding system to your attention, and hopefully we can turn some of this around.

Thank you very much.

Senator COLLINS. Thank you very much, Senator Grassley, for your excellent testimony. Your full statement and any reports or anything else you would like to submit will be published in our hearing record.

Senator Harkin, we look forward to hearing from you.

TESTIMONY OF HON. TOM HARKIN,[1] A U.S. SENATOR FROM THE STATE OF IOWA, AND RANKING MINORITY MEMBER, SUBCOMMITTEE ON LABOR, HEALTH AND HUMAN SERVICES, EDUCATION AND RELATED AGENCIES, SENATE COMMITTEE ON APPROPRIATIONS

Senator HARKIN. Thank you, Madam Chairwoman, and I thank my colleague Senator Grassley for his work in this area. We have worked together very closely in trying to ferret as much of this waste and abuse as possible, and I thank him very much for his work in this area.

Several years ago, a woman by the name of Shirley Pollack, from Atlantic, IA, wrote to me. It turned out that her mother-in-law had been in a nursing home, and she had received a statement after she got out for bandages. The statement said that Medicare had reimbursed the supplier $5,000 for bandages for 3 weeks.

Shirley said, "This is impossible. I know my mother-in-law did not use that many bandages." So she went back to the nursing home, and she was told, "This is not a bill. Your statement says 'This is not a bill.'" And she was told, "Do not worry about it; you do not have to pay it anyway."

She said, "Well, somebody has got to pay it." So she started going around to different places, and came to my office, and we looked into it and found, of course, that indeed, her mother-in-law had not received $5,000 worth of bandages in 3 weeks, but that is what Medicare had paid for because of the types of billing problems that they have that Senator Grassley just spoke about.

I started having hearings when I was Chairman of the Subcommittee on Appropriations for HHS. In 1989 I had my first hear-

[1] The prepared statement of Senator Harkin appears on page 63.

ing, and we have been having them ever since. Here are all the reports that we have right here—reports from GAO, HHS, IG, and all of our hearing records.

Now, Senator Glenn, you want an answer to what we can do about it. I have been advocating for years that only one thing is going to solve this—good old free enterprise competitive bidding.

I was shocked to learn that under Medicare, going clear back to the beginning of Medicare, pays on a fee basis that was set up years ago and is adjusted for inflation. And it just goes on year after year after year after year, and nothing is done about it.

So we started comparing—I do not know if you can see my chart over there, Madam Chairwoman—what the Veterans Administration was paying compared to Medicare. For instance, for this little syringe, Medicare was paying $2.93; the Veterans Administration paid $1.89 for exactly the same syringe. For that walker that Senator Grassley was talking about, Medicare paid $75, and the VA paid $25—for exactly the same walker. For a commode chair—which I do not have here, obviously, but I do have a picture of it right here—a simple device—Medicare paid $99.35, and the Veterans Administration for the same commode chair—I am not talking about different things; the same one—paid $24.12.

This is saline solution—Medicare paid $7.90; the Veterans Administration paid $2.38—and on and on and on. These are items that we looked at just about 2 years ago, and the potential savings that could come from them.

Why is it that Veterans Administration pays that much for the same item, and Medicare pays that much more? The Veterans Administration engages in competitive bidding. They put it out and say: If you want to supply it, give us a bid.

That is the answer to it. Now, why haven't we gotten it? Well, you said it, Madam Chairwoman—$23 billion they estimated last year—it was higher than what we had thought before. We had thought it was more like $18 billion a year. If you take $23 billion a year, and you look at the budget, where we are trying to make all these cuts in Medicare to save the Medicare system, if you could just reduce the waste and the abuse—forget about the fraud—the waste and abuse by 50 percent, you would go a long way toward saving the Medicare system without making all the cuts and doing all the things we think we have to do around here.

Why don't we do it? There is only one answer—powerful lobbies.

Look at oxygen, for example. I have been on this oxygen kick for several years—I am not taking it—but on going after the reimbursement for oxygen. We found—and these are round figures—that the Veterans Administration was paying $120 per month, and Medicare was paying $270 per month.

So we had hearings on this. We had the oxygen people in and the Medicare people in. The oxygen supply people said, "Well, there is a difference, you know. We supply all these services and all these things that add up to more money than what the Veterans Administration paid for."

Fine. I asked GAO to do an investigation into this and find out what was going on.[1] Do you know what they found? No. 1, the

[1] Exhibit No. 3 appears on page 180 in the Appendix.

same city, the same group of people, one veteran, one Medicare, Medicare paying over 2½ times as much, and actually, the veterans were getting better service than what Medicare was doing—better—at that price.

So this argument that somehow they were providing better service for Medicare is nonsense. Well, we did take a step to solve it in this budget we passed. As you know, there is going to be a cut in reimbursement for oxygen by 37.5 percent. My question is why does it take 2 years? The first year is a cut of 20 percent, and the next year, another 17.5 percent. My observations are: First, that it should have been done in 1 year. There is no reason to wait 2 years. It could have been done in 1 year. And second, why only 37.5 percent? It should have been a lot more than that. I think it should have been up in the 50 percent range, as a matter of fact. From all the evidence that we have heard, why isn't it cut more than that?

So we are just throwing money away. We are throwing it away, and there are people out there making a lot of money on this system. What I have found is that most of it is not fraud; most of it is simply a lax system out there that invites this kind of abuse. It is abuse. Competitive bidding will do it. If we had competitive bidding, look at the money we could save.

In this chart, Madam Chairwoman, last year, we reviewed 18 items. How many items is Medicare reimbursed for? Tens of thousands. But we looked at 18 items. Medicare just this year alone, if they had competitive bidding—if they paid the same as the Veterans Administration—could have saved $236 million this year—in 1 year—$1.6 billion over the next 7 years, if they had just paid what the Veterans Administration paid. That is for just 18 items.

As a matter fact, we went out and found out what the retail prices were. Those are not on there—well, yes, we do have some retail prices on there. We have wholesale and retail prices. We found out that if Medicare just went down to the local drugstore and bought retail, they could have saved $371 million over the next 7 years just by paying retail for them.

So again, I do not need to go through all of these, but again, a big part of the answer is competitive bidding. Well, good news, bad news. And finally, we got Medicare, about 3 years ago, to testify that by gosh, in fact, they could use competitive bidding. They fought it for a long time, but they finally admitted that, yes, they could use it, and yes, it would save money, after we got all this evidence and documentation on it.

The good news is that, in the bill that we passed yesterday, the budget reconciliation act, we are "permitting" HCFA to engage in competitive bidding. We "permit" them to do it. I think we should have mandated them to do it as we do the Veterans Administration. But we permit it.

And hopefully, Madam Chairwoman, with your strong support—and again, I thank you for having your first hearing on this issue, because I do not think there is a more important issue than Medicare, no more important issue than getting a handle on this—with your strong support, we can really hold HCFA's feet to the fire and get them to engage in competitive bidding right away, not down the road.

Just a couple of other things. On the itemization that Senator Grassley talked about, this always astounded me, too, because someplace, they do keep an itemized list, obviously. Then they put it all together, they bundle it and pass it on.

Several years ago, we asked about the differences between commercial technology and what the technology was at HCFA. HCFA was using outdated computers and outdated systems to look at these billings codes. I invite your attention to this GAO report that came out in May of 1995, which basically said that if HCFA just used commercial software that was out on the market, that was being used by Blue Cross, Aetna, Prudential, and all these other companies, they would save in the first year over $600 million, just catching these kinds of billing codes. Try to get them to do it—you talk about pushing on a mountain and not getting anywhere.

Well, now, finally, they are changing. But I invite your attention and also your staff to look into this because HCFA really is not moving ahead aggressively and adopting the kind of commercial technology that will catch these kinds of billing errors that Senator Grassley talked about. If you want more, I can get you more information on that.

Finally, back to the Shirley Pollack example. I know you go to senior citizens, as we all do. We go to congregate meal sites, senior citizen centers. Any time you go into one of these centers just ask: Has anyone here who has gone to the doctor or been in the hospital or received a treatment ever received a statement where there were things on there that you thought maybe should not have been on there or that you had questions about? Watch the hands go up.

The fact is that when they get it, it says "This is not a bill," so human nature being what it is, when it says "This is not a bill," you do not pay much attention to it. Plus, it is not itemized. So if an elderly person gets this, and it looks like it is too much, first of all, it says, "This is not a bill," and you do not even know what is in there—what can they do about it?

There are two things. There is an amendment that I offered that is in the reconciliation bill yesterday, and I hope it stays, that requires first of all that the statements include the toll-free hotline. There is a toll-free hotline for seniors to use to make sure this is put on the statement. And second, if an elderly person gets a statement and wants an itemized list, they can call that hotline, ask for an itemized list, and they have to receive that itemized list within 30 days. That will tend to start putting a damper on this stuff.

The other thing that we did, that we funded last year, and it is starting this year, under the Appropriations Committee, we put a couple million dollars into what we call a "Medicare Waste Patrol." There are a lot of retired people out there, Madam Chairwoman, who are retired doctors, nurses, accountants, lawyers, teachers, and professional people who could be very helpful in this. There are 12 pilot projects going on around the country—I do not know exactly what States they are in—to enlist the aid of the elderly in helping to ferret out this kind of waste using their expertise so that they can look at these statements. They can go to congregate meal sites and senior citizen centers to start to work with the elderly to help them get a handle on these bills. And that is just taking place this year, as I said, in 12 sites around the country.

Again, I am not going to go through any more of these examples; you have hundreds of thousands of them. All I will say is that I just hope that, first, we can continue to push on competitive bidding, and I ask for your help in doing that and for this Subcommittee's help. Second, to make sure we get the kind of commercial technology at HCFA that will help them catch these fraudulent—not fraudulent—abusive practices; more often than not, abusive practices, rather than fraudulent. And third, to ensure that the oxygen cuts at least go into effect, and if we can collapse it, I would hope we could do it in less than 2 years.

Thank you very much, Madam Chairwoman.

Senator COLLINS. Thank you very much, Senator Harkin. We admire your commitment to this issue and the expertise that you have developed, and we appreciate your willingness to share it with the Subcommittee.

Senator HARKIN. Thank you very much, Madam Chairwoman.

Senator GLENN. Could I ask a question, Madam Chairwoman?

Senator COLLINS. Yes.

Senator GLENN. Tom, is competitive bidding somehow discouraged in the law now? Is it actually forbidden?

Senator HARKIN. Oh, it is forbidden. The law forbids HCFA from engaging in competitive bidding. That is true. It is amazing. It is the craziest thing you have ever seen.

Senator GLENN. So it is actually in the law that they cannot go out on competitive bid to get cheaper prices?

Senator HARKIN. They have to do it on the established fee basis adjusted for inflation every year, and if new items come on, they look at what the market is like out there for these items, they set up a basis for that, and they plug that in; and they cannot engage in competitive bidding. I think that is right—yes, my staff says that is right. They are absolutely forbidden from engaging in competitive bidding.

Senator GLENN. Well, that is something we are going to want to ask about in a little while and see what we can do on that one, too.

Senator HARKIN. What you will hear is that—here is what you will hear, because I have heard it so many times, and you have got to be prepared for it. They are going to say, well, you see, if you get engaged in competitive bidding, you will not get the quality.

Well, as you know, I have been a strong advocate of disability policy, and there are a lot of people with disabilities who get wheelchairs and things like that who will say, "We will get an inferior product."

Well, my response to that is that what HCFA can do is set up quality standards. That is what the Veterans Administration does. They set up a quality standard, and they say, OK, here are the standards you have to meet for durable medical equipment, supplies and other things—now competitively bid for it.

Senator GLENN. Is the billing code issue that Senator Grassley asked about a major problem, too, in that they lump things together? That sounds to me like you pay for a Lincoln Continental, and you get the cheapest Ford.

Senator HARKIN. Yes. You have got to read this report, John. It is incredible. We have all kinds of examples. Here is an example

of unbundling, where a physician was paid for two x-ray exams on the same date of service—he is showing being paid for one—HCFA allowed $98, when they should only have allowed $75—$23 less.

Here is an example of fragmentation; an example of mutually exclusive procedures, and on and on and on and on—every one of them because of the problem that Senator Grassley spoke about in catching these.

Senator GLENN. Thank you.

Senator COLLINS. Thank you very much.

Senator HARKIN. Thank you very much, Madam Chairwoman.

Senator COLLINS. Our second panel is a panel of law enforcement witnesses. The first witness is Michael Mangano, who is the principal deputy for the Office of Inspector General at the Department of Health and Human Services. In that capacity, he directs the day-to-day operations of the Office of the Inspector General and oversees reviews that provide the Secretary with independent findings and recommendations.

The second witness on this panel is Charles Owens, who is chief of the Financial Crimes Section for the Federal Bureau of Investigation. As chief of the Financial Crimes Section, Mr. Owens has the national management responsibility for all types of financial crimes investigations, including health care fraud, financial institutions fraud, and insurance fraud. He also serves as the national program manager for the White Collar Crime Program, the FBI's largest investigative program.

Pursuant to PSI Rule 6, all witnesses who testify before the Subcommittee are required to be sworn, so I would ask that you stand and take the oath at this time. Please raise your right hand.

Do you swear that the testimony that you will give before this Subcommittee is the truth, the whole truth, and nothing but the truth, so help you, God?

Mr. MANGANO. Yes.

Mr. OWENS. I do.

Senator COLLINS. I want to thank our witnesses for accommodating the Subcommittee's need to change the hearing from yesterday to today. I appreciate your willingness to accommodate us and assist us in this problem area.

I am going to ask you in the interest of time to confine your oral testimony to 10 minutes each. The lights will cue you. At 8 minutes, the yellow light will go on, telling you that you have 2 minutes remaining, and when the red light comes on, we will ask you to wrap up so there will be time for questions.

I want to emphasize that your full testimony will be included in the record as well as any other materials that you want to provide.

Mr. Mangano, we will proceed with you at this time. Thank you.

TESTIMONY OF MICHAEL F. MANGANO,[1] PRINCIPAL DEPUTY INSPECTOR GENERAL, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Mr. MANGANO. Thank you very much, Madam Chairwoman.

I am very pleased to be here with you this morning to talk about some of the work that we have been carrying out in the Medicare

[1] The prepared statement of Mr. Mangano appears on page 66.

area. Medicare no doubt is one of the most important social and health programs in this country. With expenditures exceeding $190 billion this year, it is no wonder that it is an inviting target for those who want to unfairly abuse that system for their own profit.

As evidence of that, so far this year, we have completed 700 criminal and civil investigations that will return about $1 billion to the Medicare Trust Fund from those who have abused the program. We have also excluded about 980 health care providers who have been committing fraudulent or abusive practices in the program. In my testimony, I identify eight program areas that we think are most commonly abused today and a couple of management vulnerabilities that we think need to be closed off. But I will confine my remarks here this morning to four program areas that the Subcommittee seems to be most interested in with this hearing—home health, nursing homes, durable medical equipment, and hospital double billing.

With regard to home health services, this is probably one of the fastest growing areas of the Medicare program today, doubling the number of visits per episode per beneficiary in the last 6 years. From 1990 to 1996, the program increased from 36 visits per beneficiary to 76. Medicare paid for about 250 million visits by home health aides in the last year. The program's financial costs have really been sky-rocketing, from $3.5 billion in 1990 to almost $17 billion last year. The Congressional Budget office estimates that if we do not do anything to put the brakes on this program, it will be a $31 billion program by the year 2002. So action is clearly warranted.

We believe some of this increase reflects the aging of the population and technology increases. But unfortunately, I have to tell you here this morning that fraud and abuse are also clear culprits in some of the increases going on with this program.

In audits that we have conducted across many of the States of this country, we found individual home health agencies guilty of violations of the law with 19 to 64 percent being the range of ineligible services that have been billed to Medicare. In reviews we have done on a statewide basis in four of the largest States in the country, we have found that the rate of improper payment tends to be around 40 percent. I think that was mentioned by either Senator Grassley or Senator Harkin. That is a very disturbing result.

We think the vulnerabilities of the program are fourfold. One is the service is delivered at home; so there is very little supervision of this service. Two, there is no limit to the number of home health visits that a beneficiary can receive. Three, there is no beneficiary copayment, so there is not that natural break by the beneficiary to question the provider about whether additional home visits are really needed. And finally, I have to harken back to a Committee report here that was done in 1981, which focused on the cost-based nature of this benefit, which really prevents the home health agency from having any incentive to reduce their costs.

I want to give you an example of a recent case that we had in the District of Columbia that will give you a quick glimpse of what this process is like. The chart here on the right was used before a jury to explain how home health care visits were paid for. You have a couple of handouts which are copies of that chart as well

as a blow-up of the first two notices on the left. Basically, what happens is the home health care nurse goes out and delivers the service at site, come back and fills out, in this case, a time slip that goes back into their accounting office which pays that nurse for that visit. The form at the bottom is called a "Skilled Nursing Visit Report," and it gives the details on what was wrong with the patient, who he went to, all the details of it.[1]

Now, if this is a Medicare bill, those forms will go to the Medicare agency. The contractor for the District of Columbia was Independence Blue Cross. The contractor will pay that bill. If it is Medicaid, it goes into the Medicaid agency for the District, which was First Health Services Corporation. Then the District pays that bill.

What we found in this particular case was that over 1,400 home visits lacked any documentation that a visit was made. That is, those first two sheets were not completed. You might be surprised to find out that some of those visits were to beneficiaries who were in hospitals, which would clearly be illegal. That home health care owner was fined $100,000 in restitution to the program and sent to jail for 2 years; his co-owner has fled sentencing.

The key here, we think, in home health is with the physician. The physician is really the gatekeeper of the system. Some of our audits have found that the physicians ordered home health care visits without even knowing the patients or examining those patients.

We think there are a few solutions to this problem. In order to protect the benefit and seal it off from some of these abusive practices, we think a couple of things have to happen. One, the law needs to be changed so the physician must be required to actually examine the patient and then do so on a periodic basis thereafter to ensure that the patient really needs those home health care benefits.

The second solution is very much in concert with the report that was completed by this Subcommittee in 1981. That is, we should increase focused reviews by the Medicare contractors to zero in on those providers that we think are most abusive, and we should do more periodic audits of their records.

And finally, a move to the prospective payment system will, we think, put some brakes on this process.

Nursing homes are also a fairly growing segment of the Medicare and Medicaid budgets, last year accounting for about $46 billion. Our chief concern here is a growing movement to cost-shift from Part A, which most people consider the nursing home bill, to Part B—that is, having service providers and product providers like durable medical equipment salesmen coming into the nursing homes and billing the Medicare program directly, not through the nursing home.

One of the consequences of this is that the beneficiary then has to pay a copayment. Just as a couple of examples of that, we found $17 million in mental health services being billed to the Medicare program that were inappropriate; that is 24 percent of all mental health services in a nursing home setting. We found psychological

[1] Exhibit No. 4 appears on page 197 in the Appendix.

services being billed as group therapy when in fact they are really social events.

In this area, we think a prospective payment system is needed for Medicare Part A, and for those bills that fall outside of Part A, we think a consolidated bill ought to be put together and sent from the nursing home, not from the disparate service and equipment suppliers.

A lot of discussion occurred in the last panel on durable medical equipment. This really has become a nagging problem that consistently harms the Medicare program—services not delivered; products charged that were more expensive than the services that were provided; unbundling, that is, taking a piece of equipment apart and billing it separately so that the reimbursement is at a much higher rate; unnecessary services; excessive prices—you name it.

Whenever we see a big spike-up in a particular product, that causes us to say something may be going wrong here; that causes us to get involved with doing our audits and investigations. Some of those products that we have spent a lot of time with over the years deal with incontinence supplies, lymphoedema pumps, power-operated vehicles, seatlift chairs, orthotic body jackets, and the list goes on and on. This is a high-profit industry for a number of reasons, including ease of entry, and the safeguards are really not as strong as they need to be.

I want to give you one example of an abuse that really has sort of a happy ending that shows what we can do when we really put our effort to it. We have testified a number of times on incontinence supplies. These are supplies dealing with persons who have incontinence problems. In 1994, Medicare paid $260 million for these incontinence supplies. We found abuses in two areas—one, where persons were billing for urinary collection pouches at about $7.38 apiece, but actually delivering 33-cent diapers, which are never reimbursable in the Medicare program. We also found devices that were being billed that were not being billed in concert with a prosthetic device, like a catheter, and that is not covered by the Medicare program. So $260 million was billed in 1994.

Because of the reviews that we did, the investigations, which have brought back about $45 million—and I have to say the very prompt action of HCFA in instructing their carriers to pay a great deal more attention to those bills—we were able to reduce the incontinence bill that Medicare pays by $100 million in just 1 year. That is a dramatic drop, but it shows you the abuse that was going on in that system.

We think that one of the things that we can do to clean up this industry is to require surety bonds on the part of the salespersons. We think that there ought to be onsite visits at the beginning when suppliers apply to bill the Medicare program. We think that there ought to be some more generalized recommendations to deal with some of the systemic problems. We clearly endorse the recommendation of Senator Harkin that there ought to be more competitive bidding here and to increase the ability of Medicare to reduce a price when it becomes inherently unreasonable, when they are clearly paying too much money.

The last area I want to mention is the hospital double-billing. Medicare reimburses for inpatient care on the basis of the diag-

nosis of the patient. That is the prospective payment system. All the services that are delivered to that patient for that inpatient stay are supposed to be included in that. One of the regulations they have is that any related nonphysician service delivered within 72 hours of that visit ought to be encompassed by that.

What we have found, though, is that a number of hospitals have been billing outside of that 3-day (72-hour) window, primarily for nonphysician outpatient services, and typically, laboratory services that get billed. In our reviews, we found about 4,600 hospitals that were billing this extra or duplicate bill for that. This is a problem that equated to about $100 million. We are now doing our fifth review. After the fourth review, we went back and told the industry that this billing practice was abusive, and even after Medicare had collected about $100 million, they were still doing it. We engaged with the Department of Justice and are pursuing these cases under the Civil False Claims Act. We believe we will recover about $100 million there.

Madam Chairwoman, I thank you for the opportunity once again, and I would be happy to answer any of your questions.

Senator COLLINS. Thank you very much.

I want to welcome Senator Durbin, who has joined us. I also want to explain that unfortunately, we are going to have votes all morning. Senator Glenn and I are going to switch off voting to try to keep the hearing going, since it is likely to be a busy day.

I am going to ask Mr. Owens to proceed now, and then we will question the whole panel after your testimony.

TESTIMONY OF CHARLES L. OWENS,[1] CHIEF, FINANCIAL CRIMES SECTION, FEDERAL BUREAU OF INVESTIGATION

Mr. OWENS. Thank you. I appreciate the opportunity to be here today representing the FBI in this important hearing.

As the Subcommittee is well aware, the FBI has identified health care fraud as a top priority in recent years and is increasingly devoting more resources to it and conducting more investigations. The Health Insurance Portability and Accountability Act of 1996, with dedicated funding for several years, a Federal health care offense, and other provisions was a shot in the arm to this effort. Federal law enforcement is in a better position to combat this serious financial crime problem today, and we greatly appreciate the support of Congress with the passage of this Act.

This appears to be chart day, and we too have brought some charts, although I think ours are the only ones that have a purple background. I would like to refer to them very briefly, and there is a total of five. I think they will give you a good summary of what the FBI is doing in our efforts to combat health care fraud.

The first chart, which is the one on the left, reflects the commitment of our agents to health care fraud investigations.[2] Our real emphasis in this area began in 1992, at which time we were using approximately 112 agents to investigate health care fraud matters. And you can see that incrementally, we have increased that effort to the point where, at the end of the second quarter of this fiscal

[1] The prepared statement of Mr. Owens appears on page 77.
[2] Exhibit No. 5 includes charts (a) through (e) appears on pages 200–204 in the Appendix.

year, we were using in excess of 350 agents to combat health care fraud. We are now close to the end of the third quarter, and that number is up in the range of 370 agents. And of course, with the funding that is provided from the HIPAA, that will continue to increase over the next several years.

The second chart reflects the caseload that we have had during the same time period. Again in 1992, we had 591 investigations open at the end of that fiscal year, and that number as of the second quarter has increased to in excess of 2,300 investigations, about a 290 percent increase during that period of time. And frankly, that is an extremely high number of investigations. These are very complex investigations, and although our commitment of agents may continue to go up, I would expect that our caseload would not increase dramatically from that level because of the complexity of the investigation.

The next chart reflects the number of convictions that have been obtained. Many of these are from multi-agency investigations—from 116 convictions of both individuals and corporations in 1992, as of the end of the second quarter this year, we have achieved 284 convictions, and if you annualize that, you can see that at the end of this year, we should achieve well over 500 convictions in the health care fraud investigations.

The fourth chart reflects the breakdown of the total health care expenditure, which is about $1 trillion, and of course, the FBI investigates not only frauds against Medicare and Medicaid and the other Federal programs, but frauds against the private payers as well. That breakdown reflects 56 percent of the costs are with private payers, 44 percent with government programs. But the inset in the left corner reflects that of the 2,300-plus cases we are investigating, 60 percent of them involve fraud against some Federal program. And again, we tend to classify our cases either as private or Federal, and many times the unscrupulous individuals are defrauding both the private payers as well as the Federal programs, and in the instance where the Federal programs are defrauded, we would classify it that way.

The final chart which we will put up here I think shows the direct impact of the HIPAA legislation and the funding associated with that. Our emphasis in our larger field offices that are experiencing the greatest problems has been to try to get dedicated squads, full squads, to investigate health care fraud, so the agents are not diverted to a multitude of white collar crimes but can concentrate just on health care fraud. And of course, it is a very complex area that requires a lot of training of our agents to make them competent to investigate these areas.

Prior to the enactment of HIPAA, we had dedicated squads in a number of field offices reflected in the chart here—Boston, Chicago, Dallas, Miami, Newark, New Haven, New York, and WFO. As a result of the additional funding and the additional agents we were able to apply to this, we have added squads in Cleveland, Los Angeles—in Miami, we have added another squad, so we actually have three squads investigating health care fraud in Miami now—as well as New Orleans, New York to a second squad, Phoenix and Tampa.

I think that shows the direct impact of the legislation that has better enabled us to fulfill our responsibilities in this area.

As a result of FBI investigations and our assessment of the vulnerability of the health care system to fraud, as has been stated here previously, no segment of the health care system is immune to fraud. In my statement, I have summarized a number of significant accomplishments in areas such as laboratory billings, home health care and durable medical equipment, and many of these accomplishments resulted from joint and multi-agency investigations, which I think are really important that we do in this area.

Much has been said about the substantial penalties levied against several large corporations operating independent clinical laboratories, and this is only one area of health care fraud. But in the Midwest, five individuals defrauded Medicare of more than $25 million in marketing durable medical equipment to nursing homes and were charged in that case with the RICO statute, which I think is an important development and a statute that we can continue to utilize to make more significant impact in health care fraud.

And in another case, a Pennsylvania man who established bogus companies not only in Pennsylvania but also in Florida and Texas obtained a provider number and caused losses to Medicare of over $12 million by billing for noninvasive laboratory services when in fact his company had no employees and no one was ever tested. He and two others have pled guilty and are scheduled to be sentenced in the month of July.

Health care fraud is causing a serious financial drain on this country, and we must continue our collective efforts to combat it. The FBI is working closely with the Inspector General of the Department of Health and Human Services, the Defense Criminal Investigative Service, and other Inspectors General, the Health Care Financing Administration, State Medicaid Fraud Control Units, and the United States Attorneys throughout the country, often in task forces, to address this problem. We are using the full array of investigative techniques including undercover operations and are increasingly using civil as well as criminal remedies in this effort. We are hopeful that through our continued collaborative efforts, we can begin to reduce the level of health care fraud.

That concludes my initial statement, and I will be happy to answer any questions.

Senator COLLINS. Thank you very much, Mr. Owens.

Mr. Mangano, I would like to go back to an example that you gave in your testimony about the home health care provider who actually billed HCFA for over 1,400 skilled nursing visits for which there were neither time slips nor nurses' notes documenting that the visits were made. Could you tell us more about this individual, what was his background, and how easy is it for someone to become a home health care provider?

Mr. MANGANO. I do not have information on that particular provider, but it is fairly easy to become a provider in this program, and that is why we and HCFA together believe we ought to do some things to make it harder to become a home health services provider in this area.

One of the problems with this benefit is that under current law, a home health agency could actually provide one service, like bathing a home-bound patient, and subcontract everything else out. Then you get into problems with abusive subcontractors.

I will give you one example that occurred in Florida which I think really gets to your question. In Florida, the Medicaid agency asked providers to resubmit their applications because they thought people were doing abusive things both in the durable medical equipment area and I believe in the home health area. Only half of the providers resubmitted applications. So we think there is a lot of abuse here. People get into this program easily. We had one case where a person who was an ex-felon applied to be a home health provider. He had a friend who was a nurse who really became the front for the organization. As soon as the person got his provider number, the nurse left, but he had the business.

One of the legislative fixes that we are supporting is for Medicare to have the opportunity to exclude people from ever entering into the program if they have prior criminal convictions. We think that will go a long way toward excluding some of these nefarious persons.

Senator COLLINS. I would note that the staff has informed me that the person you cited in your testimony had no background in home health care, and indeed had been a D.C. cab driver before getting into home health care; so I think that does suggest that perhaps we do need more screens in that area.

I am going to have to leave to vote, and I do not know whether Senator Durbin wishes to go and vote now also. We have 4 minutes remaining.

Senator DURBIN. Could I ask a question before we leave?

Senator COLLINS. That would be great, and Senator Glenn will Chair the hearing until I get back.

Thank you.

OPENING STATEMENT OF SENATOR DURBIN

Senator DURBIN. I will only be able to stay for a few minutes, but I wanted to ask a question. I read over the testimony from Mr. Mangano and Mr. Owens, and it seems like the problem in home health care is that there are no onsite visits and reviews of records, and there are not a lot of whistleblowers out there. I can understand if a person is frail and elderly, they are not watching every move made by a home health care provider carefully auditing the equipment that is being delivered against what is being charged. That is probably more than we can ask.

I believe in home health care. You can look at it in terms of cost and where people would like to be to receive their care, and it seems like something we should move toward. How do we build into this system some safeguards to avoid the kinds of abuses that you are all reporting today?

Mr. MANGANO. Well, I think one of the problems is that with home health services, since the beneficiary does not have a copayment, the Medicare program does not send them an explanation of medical benefits. If a beneficiary could see that explanation of medical benefits, it would indicate the services that they have received.

One of the problems we have found is that services that are being billed are not actually being provided, so a beneficiary would see that they did not get that service on that particular date.

Senator DURBIN. What is to stop that statement from being sent whether or not there is a copayment—I mean, the copayment we are talking about is $5.

Mr. MANGANO. OK, yes. Medicare right now is doing an experimental program where they are actually sending the explanation of medical benefits. We expect to hear the results of that fairly shortly. I believe they are doing that in Florida, and we think that will prove to be efficacious for the program. We think that it then ought to be mandated across the entire program.

Senator DURBIN. Let me tell you what we did this week. We just voted in the Senate to raise the eligibility age for Medicare from 65 to 67. It is estimated that over 5 years, that will save us $10 billion. It is very controversial because it means that some 7 million Americans at age 65 have got to have their own health insurance when this is fully implemented and that Medicare will not cover them. I opposed it and had an amendment which lost in an effort to stop it.

But I look at this, and we have a situation where we are reporting up to $18 billion a year that we are losing in Medicare fraud and waste, and I am thinking to myself, we are going to toss 7 million people out of Medicare eligibility and tell them: Go and find your own health insurance because Medicare cannot afford you anymore. And we have $18 billion—do you think that is a fair estimate, Mr. Mangano, of the amount of waste and abuse each year in Medicare?

Mr. MANGANO. Well, the $23 billion figure that was mentioned a little earlier was for improper payment. That included everything from fraud, waste and abuse to mistakes that providers made. However, it did not look at the entire range of fraud and abuse.

So there is clearly fraud, waste and abuse in the system, and we have to do a better job at trying to find it. If I could go on just a little bit with home health services, we took a look in one of our other reviews at what the cost of home health services was in Medicare risk HMOs. The HMOs actually have to provide their own home health benefits, and most of them do it on a contract basis. They were paying about one-fourth of what the fee-for-service Medicare program was paying. The reason that was so much less is they had somebody managing the benefit; so there was somebody determining whether the beneficiary should actually receive the services or not. The HMO is a prudent purchaser of those services. When it is left primarily to the home health agency to determine or to affect the number of visits, you have this dramatic increase. Many of the old line home health agencies, the ones that we all remember from our youth, were averaging about 33 visits per beneficiary in the time that we reviewed it. But the newer, unaffiliated for-profits are averaging about 102 visits. I think that says a lot.

Senator DURBIN. I am sorry to have to leave. I am told I have 12 seconds to get to the floor. So we will have a brief recess at this point until Senator Glenn returns.

Thank you very much for your patience.

[Recess.]

Senator GLENN [presiding]. The hearing will be in order.

I apologize for the truncated nature of things here, but it is beyond our control. We have votes on the floor, and they are going to be running about every 20 to 25 minutes or something like that, I am afraid. So that is just the way it goes.

According to this past February's High-Risk Report on Medicare, fewer than 1 percent of all Medicare-certified home health agencies received on-site, comprehensive reviews. That was as of 1994. Now, it is difficult to detect something if it is not going to get checked often and on a bigger percentage than that, of course, to really get into this thing.

The GAO's quote in their report was: "Comprehensive medical reviews are an essential component of post-payment reviews of home health agencies." Mr. Mangano, is that 1 percent rate of on-site inspections still about the rate today, do you know?

Mr. MANGANO. I think it is somewhere between 1 and 3 percent that actually get reviewed. Now, these are full audits of the benefit. This would involve somebody taking a look at the medical record and determining whether the beneficiary needed the service, what physician ordered them, and so on.

But it points out a problem with the program. Back around the mid-eighties, they were doing reviews of about 60 percent of the claims in home health. Home health has grown from a $3.5 billion program in 1990 to just under $17 billion last year.

The Medicare program is just inundated with so many claims—over 800 million claims for all services across the program—that they are really unable to spend enough time with any individual claim.

For Medicare program safeguard activities—these are the kinds of things that would be included in audits and more detailed looks at providers—from about 1988 to just last year, they have only increased that budget by about 11 percent; but the number of claims has increased probably 70 percent in that time frame. Last year, under the leadership of persons like yourself, with the Kassebaum-Kennedy bill, you turned that around and are now giving HCFA a more definite increase in program safeguard activities. This year, they will have about $440 million.

As they get more money to do that, we think they will be more effective, but the bottom line problem is they did not have the money; they did not do the reviews; and if they do not do the reviews, people will abuse the program.

Senator GLENN. Mr. Owens, is the FBI geared up to take this on? Do you have enough manpower to get into this thing? What I mean is that, as Mr. Mangano points out, we have had an explosion over the past 5 years in this area, and I do not think that our number of people have kept up with it. Are we able to really monitor this in a meaningful way?

Mr. OWENS. I think the criminal matters that have come to our attention—we have shown in the charts that we have submitted a dramatic increase in both the number of agents committed to it and the number of cases. But we are having to be selective in the cases that we work, to try to work the most egregious cases where we can make the most impact.

Senator GLENN. I will ask you both about this. How much of this is just pure, old fraud, crooked dealing, crooked billing, as opposed to systemic problems as billing codes and things like that that Senator Grassley mentioned a little while ago? Is the billing code thing a major problem?

Mr. MANGANO. It is a major problem in some areas, particularly in the durable medical equipment area, where some of the codes are broader than they should be. They encompass several different kinds of pieces of equipment that fit that code. When people decide to abuse the program—and I have to emphasize it is their decision to abuse it—they know what they are doing. When they supply something that is less expensive—when they do that, it is very difficult to catch.

We find coding problems also in other areas of the program—hospital admissions, for example, where we find some evidence of hospitals charging for a higher diagnosis code than was actually delivered. In physician offices, we find those problems as well.

I have to echo what the Chairwoman said earlier this morning, that most providers are honest, decent people, who play by the rules in this program, but there are others who do not do that, and they want to enrich themselves at the expense of this program

Senator GLENN. Is your IG staff adequate to take all this on? I am a big supporter of the IGs; it was my legislation that expanded the IGs here, so I have worked very closely with the IGs, and I think that in general, they do an excellent job. I think it is one of the real success stories in government. But do you have enough people to get into this, and could you really make a major dent if you had more people or more resources?

Mr. MANGANO. Clearly, we could do far better with more resources. That is why last year, the Kassebaum-Kennedy bill was such a welcome addition for us in that it will give us increases over the next 7 years and will help us do our job far better.

Let me give you one statistic which I think may get to your question. Our office is made up of evaluators, investigators and auditors by and large, in addition to some of our legal staff. We now have about one investigator for every $1 billion in Medicare expenditures. Now, we are going to be growing over the next few years, and we are going to do a better job, but it shows you where we are starting from.

Senator GLENN. Has asset forfeiture ever been applied in this area like it is in some other criminal areas, Mr. Owens?

Mr. OWENS. Certainly.

Senator GLENN. Is that an effective tool?

Mr. OWENS. I believe it is, sir, yes. We attempt to use that as a remedy in this area to the full extent that we can.

Senator GLENN. Are there any cases you can tell us about where that has worked, where you really went after people and got a lot of money back on asset forfeiture?

Mr. MANGANO. I can give you one example.

Senator GLENN. Good. Mr. Mangano, go ahead.

Mr. MANGANO. Down in Florida, we had a durable medical equipment salesman who had stolen $70 million from the program. We were able to attach his assets and get back about $34 million that,

under other circumstances, if we had not had asset forfeiture, may have been very difficult to get.

Mr. OWENS. I am told that in the one example I cited of the Pennsylvania man who created a company that virtually had no employees and did no testing that we did apply asset forfeiture there, and that we are going to recover in the range of $1 million in that particular case, too.

Senator GLENN. Good. And the asset forfeiture laws do apply in this area as well as other areas, I gather; is that correct—we do not need additional legislation, then?

Mr. MANGANO. That is correct, and one of the provisions of the Health Insurance Portability and Accountability Act last year was that the asset forfeiture seizures would be returned to the Medicare Trust Fund. So I think it will help improve that situation.

Senator GLENN. Senator Harkin says he thinks competitive bidding is going to solve much of this problem. In your view of this, having worked up close with it, do you think that is a correct analysis?

Mr. MANGANO. Absolutely. We have done any number of reviews. We and the General Accounting Office have looked at this oxygen issue for the last 5 years, and it just proves so clearly that competitive bidding would help. In all the durable medical equipment areas, competitive bidding will help.

Now, it is going to be a little different than what the Veterans Administration does, because the VA will competitively bid for all of its business across the country, or bid for regions of the country. Since Medicare is dealing with individual beneficiaries, the competitive bidding process has got to be a little different. But they can do more localized competitive bidding, allowing companies to bid for contracts on those products for those areas. It clearly will bring the price down.

Senator GLENN. Mr. Owens.

Mr. OWENS. Yes, I would agree. I think one of the problems that is occurring here is that the profit potential is so great for these companies that it encourages people to come in and bilk the system, and if the profit levels were brought down with competitive bidding, I think that would discourage a lot of people from coming into the business.

Senator GLENN. Do you get much help from whistleblowers, from people who feel the bill they have gotten is not correct, and they let you know about it, or other people who work in the system somewhere, in HMOs or in doctors' offices or equipment suppliers or whatever, who see these things happening and, just out of plain good citizenship let you know? How often does that occur? Do we need more hotlines, fewer hotlines, more encouragement in that area? Would that help?

Mr. MANGANO. We do have a hotline, and we have been operating it in its current mode for about the last 2 years. In that time frame, we have been able to recover just under $8 million. These tend to be very small claims—individuals looking at their bills and finding problems with them. So we have found it to be useful in that it has brought that kind of money back.

There are also a number of cases that we are doing right now that we have not completed which could bring substantially larger amounts of money back to the Medicare program.

There is also another activity called the qui tam provision, which is really for whistleblowers who file with the Department of Justice. In the last 3 years, we have had an explosion in the number of qui tam suits. Private citizens bring suit against a provider for abusing the program and ask the Department of Justice to join that suit.

Three years ago, we investigated 40 of those cases. This year, we will probably do 200. So I think that shows you the explosion in that area. We have already brought back well over a quarter billion dollars through qui tam suits over the last 5 years.

Senator GLENN. Has the Department tried any outside contracting with people who would do the policing, in effect, and would do the analysis of billing and so on, and bring those cases to you? Has that ever been done?

Mr. MANGANO. Well, the one project that Senator Harkin talked about that was put into legislation just this past year creates a system of senior citizens who will work in their local communities as educators and resources. They will work with senior citizens at local places, senior centers and the like, to help them understand what is fraud and abuse and how to report it. That has just been created. I think the grants that were given out are being managed by the Administration on Aging, and we are working with them in that. Over the next year, we will have an opportunity to see how that works.

Senator GLENN. That is one direction, but what I was thinking more about was some private group that would be like a private investigator that would investigate these things and bring them to your attention. Has that ever been done on a full-time basis? In other words, they would be somewhat the same thing you do in your shop, I guess, except by contract outside.

Mr. MANGANO. Well, over the last several years, the qui tam provision has enabled a number of law firms to start hiring private investigators. That is one of the reasons we are seeing such an explosion in the qui tam suits.

Mr. OWENS. Senator, if I could just comment briefly on your question about cooperating individuals, while we have not seen a lot of individual beneficiaries come forward with relatively small individual claims, we have a number of cooperating individuals who are people operating within the health care industry who have been extremely helpful to us. I mentioned that we have several ongoing undercover operations, and we have used this technique in the past to address areas of fraud here, and a number of people operating in the industry have worked with us and are assisting us in this effort.

Senator GLENN. Our end of this whole thing is to make sure that the legislation end of it is taken care of, that we have the proper laws on the books that will address this and then go for enforcement on it.

Do we need any additional laws, or is it adequate out there right now?

Mr. MANGANO. Well, we are endorsing a few of them. One of them is not to apply the bankruptcy provisions to persons who defraud the Medicare program or other health care programs and try to immediately declare bankruptcy.

We have in a number of situations had small firms that have defrauded our program. Once we find out about them and realize that this could be a substantial fine and penalty for them, they declare bankruptcy. Under the bankruptcy laws, we cannot then get that money back. We are asking that bankruptcy protections not be applied to the Medicare and Medicaid programs. At some point in the future when that provider has the money, we want to be able to get that money back.

We also find some scams like, once we get on their trail, they will give the business to a family member or to a close friend who will operate it, and they actually stay in the business themselves. We think that is important. Most important, we are asking Congress to allow the Medicare program to collect Social Security numbers for the health care providers. This will enable us to track them over time. When somebody gets in trouble with us one time, if we have the Social Security number, and they get involved with the business somewhere else, we can track them more easily.

Senator GLENN. Does the Privacy Act prevent that now?

Mr. MANGANO. Yes. We believe that there are problems with being able to collect it right now, and that is why HCFA and we are asking for a legislative change. We think that if a State can get the Social Security number for our driver's license, Medicare ought to be able to get it for its health care providers.

Senator GLENN. Yes, I tend to agree with you.

Mr. OWENS. Senator, in that area also, if I might, both the Department of Justice and the FBI recognize a few areas where we think there could be some improvement. One is that under the Federal Rules of Criminal Procedure for the grand jury proceedings, currently, we can only use information gathered pursuant to grand jury subpoena in criminal cases. We have increasingly begun to work more and more civil cases in this arena, and it would be helpful to us if we could use information gathered in the grand jury process in civil proceedings.

In another area, the kickback statute currently applies only to the public-sponsored programs. It would be helpful to us if there were a kickback provision which applied to the private insurers as well.

The third area would be that pursuant to the Kassebaum-Kennedy Act, the Department of Justice was given the authority to issue investigative demands to obtain records, and that process is only useful now—we can only apply it in criminal cases. That also would be appropriate, we believe, in civil cases, and that would be helpful.

Senator GLENN. All right, good. With the Chairwoman's permission, we might want to have staff work with you on the proposals that you think we should be making here to strengthen what you are able to do. I think that would be a good idea and that is something positive that could come out of this.

Mr. OWENS. We would be happy to do that.

Senator GLENN. Madam Chairwoman, if I might just ask one more question. We have some 822 million claims a year. That is an enormous job. And just to separate it down into one area, it is only 1 percent within home health care, let alone the whole 822 million, where there is enormous possibility for fraud and abuse.

Now, you have coming online eventually the MTS, or Medicare Transaction System, but there are still problems with that, and I will tell you, like the old job, it is "deja vu all over again"—we have been through this with tax system modernization on this Committee with the IRS, where we have about $3.5 billion in computers and so on over there now, and the system has just never come together yet.

I have a couple of questions—first, your opinion of this, and is it going to work, will it help you if it really comes on? And a second question is are you working with IRS to make sure that some of the same mistakes are not made here that were made over there? They have an even larger problem over there with the hundreds of millions, or trillions, or whatever it is, of pieces of information they have to process every year. But in this 822 million claims you have, it would seem to me that some sort of an information system like this is going to be critical to really getting control over this; but you have to make sure you do not make some of the mistakes they made over there.

I guess that is a statement as much as a question, but would you comment on that?

Mr. MANGANO. Sure, and I think that is probably a question that would most properly be dealt with by the HCFA representative, who will be testifying a little later. But I do know that they are working within the Department and looking at examples of other organizations that have put systems up.

Eventually, when the MTS system is in place, I think it is going to be a great help in this area, because it is going to be able to consolidate bills across Part A and Part B, so they can see where the glitches are. It is awfully important to find out all the bills that providers are issuing for an individual beneficiary, and the same thing for the beneficiary side. We really need to know how this thing works.

I know the Health Care Financing Administration is also spending a lot of time these days on developing information systems that will help them in the fraud area. For example, they contracted a year ago with Los Alamos Labs to develop some logic systems that will help them to identify aberrances that would cause them to then get involved in and to take a more detailed look at it. They are developing a number of information systems that will help them do a better job in this area.

Senator GLENN. Thank you.

Thank you, Madam Chairwoman.

Senator COLLINS [presiding]. Thank you very much, Senator Glenn, for your questions and for presiding.

Mr. Owens, I would like to turn to the issue of how much penetration there is by organized crime in the area of Medicare fraud. Last fall, the *Miami Herald* reported that health care fraud was not only growing, but that it was becoming increasingly violent and organized; and indeed, one of the local FBI agents in Florida,

speaking at a fraud seminar, said that seven local kidnappings and 14 homicides had been linked to health care fraud. Similarly, the article in the *Miami Herald* went on to report that the growing payoffs and violent punishments are just two signs that medical fraud is increasingly controlled by well-organized rings headed by kingpins experienced in directing criminal enterprises. And he went on to say that there were actually cases where drug traffickers had gotten out of that illegal enterprise because they found health care fraud to be more lucrative and easier to commit.

To what extent has violent and organized crime entered the world of health care fraud? How much of a problem do you think this is? Is it growing, or was this just an isolated incident?

Mr. OWENS. I think we should break it down into two categories. There has been some discussion in the past about the level of traditional organized crime elements involved in health care, and I think that is fairly limited. We have had just a handful of instances where that has occurred. When it does occur, we certainly give it priority.

On the incidents referred to in Miami, we spoke at length with our supervisor there, and he insists he was misquoted as to specific numbers, but I think the underlying theme there is true—there have been a number of incidents of violent crime in the Miami area involving health care industry participants, and that has caused us some concern. There is a Violent Crime Task Force in Miami that has worked a number of these cases, and they have prosecuted a number of people for it. But that is a trend that we have seen there, and we are looking at it.

To the extent that we could ever identify organized rings involved in health care fraud as well as violent crime, such as kidnappings or murder or extortions, we would be very aggressive in attempting to apply the RICO statute there. We have had discussions with the U.S. Attorney's office in Miami and the Department of Justice about doing that very thing.

But at this point in time, we really have not been able to develop a tremendously close link there, although there are incidents where a number of violent criminals have infiltrated the health care industry. And in some instances, as the article indicates, we know that prior convicted drug felons have entered the industry.

So it is a problem, and we are looking at it, but I think it is fairly isolated. We have not seen it to a large extent in other areas of the country. We see ethnic groups involved in systemic types of fraud in the industry, but we have not seen the violence associated with it in other areas as much as we have in the Miami area.

Senator COLLINS. Why is Miami such a center for Medicare fraud? I noticed the concentration of your FBI health care squads in that area. Is it just that the percentage of elderly people living in Florida makes it a tempting target? Is it tied to the drug trade? Why the problems in Southern Florida?

Mr. OWENS. It is probably a combination of things. One of the things we did when we started to allocate the additional resource that we got from last year's legislation was that we looked at the expenditures of Medicare and Medicaid around the country, and we determined, I believe, that 10 percent of the expenditures are in just Dade and Broward Counties, obviously because of the elderly

population there. But there has been a tremendous explosion in the number of health care providers that have located in that area, and as I said, we do have instances of other criminals infiltrating the industry there. So I think it is really a combination of factors. And we have three full squads dedicated to health care fraud, probably 30 to 35 agents investigating health care fraud in Miami.

Senator COLLINS. In view of the magnitude and scope of the fraud, abuse, wasteful practices, the combination of the factors we have been talking about, I want to follow up on the questions that Senator Glenn has asked you previously: What can we do about fraud in the Medicare program? To understand what remedy is most appropriate, we have to understand more about the vulnerabilities of the system, and I would be interested in having both of you identify the primary weak link in the Medicare chain, that is, what is the primary reason why the system is so vulnerable to the kinds of abuses that we have talked about today?

If we could start with you, Mr. Mangano.

Mr. MANGANO. Well, it really differs by the service area itself. In the home health area, the specific vulnerabilities are that it is a cost-based system, there are no limits on the benefits, there is no requirement that a physician actually see a patient and diagnose the patient for the plan of care. The physician has to write the plan of care but does not have to see patients or diagnose them.

Those are some very powerful vulnerabilities in this system, and we have to reverse that. We have to have the physician playing a more important role, like requiring the physician to actually see the patient and diagnose the patient before he writes the plan of care.

We think that the cost-based system is just plain wrong. There ought to be an incentive on the provider's part to keep costs reasonable. Moving toward a prospective payment system, a cap on the number of services, or a cap on the dollars of services would all be good methods.

In the nursing home area, we have this split between Medicare Part A and Medicare Part B. Medicare Part A is a cost-based system, where the nursing home determines what its costs are and then bills the Medicare program for that. Then they start to split out services that they can bill under the Medicare Part B program. But the nursing home is not actually billing it themselves. You will have service providers come in from the outside and say, "We can take care of your patients' psychological problem; we will come in three times a week and visit your patients." Now, from that outside provider's point of view, this is wonderful, because they have a captive audience of a lot of people whom they can bill for.

The same thing happens with durable medical equipment suppliers. They will come in and see this vast array of potential persons they can bill against. Well, the nursing home never even sees those bills, so there is nobody in charge of really seeing what the total cost of care is for that beneficiary.

We think we need to go to prospective payment here to cover all the Medicare Part A costs and really fold it together with Medicaid and then, for the Part B side, have one consolidated bill that comes from the nursing home, not from the durable medical equipment suppliers or the other persons who deliver services in that setting.

With the hospital problem of double billing under Part A and Part B, we think a solution here is to implement compliance programs. One of the things that we are spending a lot of time on these days is to develop a voluntary compliance program for each industry that we are working with. We released in February a voluntary compliance plan for the laboratory industry. The lab industry in the last 3 to 4 years has been subject to over $800 million in recoveries in the Medicare and Medicaid programs because of abuses that they have perpetrated out there in their community.

So what we have basically done is say, "Here are the things that we think you ought to do as an industry to stay in compliance. You have to do things like give somebody in your organization responsibility for fraud and abuse, train your staff, have periodic audits to make sure that you are billing properly, and reporting billing abuses to appropriate authorities when they are discovered, and so on."

We work with the industry to develop that; so it is a cooperative arrangement. We are now moving into the hospital area, and we will be moving through each of the major industries. We think industry has just as much at stake in coming up with effective compliance programs.

Senator COLLINS. Mr. Owens.

Mr. OWENS. Just very briefly, obviously, there are a number of factors that play into it, but certainly, the growth in the amount of expenditures in the program as well as the growth in the number of claims have made it very difficult, I am sure, for HCFA to keep up with that.

But I think one of the primary problems is the level of controls that can be instituted into the system, from the way provider numbers are obtained to systems of looking for aberrant payment patterns, things of this type.

This is a little bit beyond our area, of course, because we just do investigations, but what I think is important and plays into the effort here is that whenever we complete an investigation and convictions are obtained, we disseminate a memorandum to the Department of Health and Human Services as well as the U.S. Attorney's offices, indicating what our investigation uncovered, and hopefully, those serve to help them identify areas where they might want to make improvements.

Senator COLLINS. I have a few more questions. First, I would like to know how each of you would evaluate the performance—and perhaps this is really more of a question for you, Mr. Mangano—of the fiscal intermediaries with which Medicare contracts? How effective are they in protecting the Medicare program against fraud and abuse, particularly in the home health care industry? You have given us disturbing statistics based on your audits and investigations for a number of questionable claims or improper payments. That suggests to me that somebody is not watching the store very well, that someone is not doing an effective job of checking.

Mr. MANGANO. Well, I think I have to answer it in this way. The Medicare contractors get paid on the basis of the number of claims they process and on how quickly they process them. There is a cost per claim that I believe is under $1 or $2 for each claim they review. So we have to think about what is possible to review with

less than $2 per claim. That means that you are going to be doing a very cursory review to see if the services were provided.

Unfortunately, those claims will merely state the service that was delivered. The contractors do not receive the medical record that goes with that to determine whether the service was needed, how it was delivered by a physician, and so on.

On the program safeguard side, the amount of money that has been given to the contractors has really been stagnant since 1988, except for the big change that occurred in last year's legislation. We think they will do a better job in the future because they will have more money to spend on those kinds of activities. As they do that, their job will get better.

They also need better edits. When they see claims, there ought to be ways to institute edits on the basis of the investigations that the FBI and ourselves have undertaken and on things that HCFA knows about the kinds of abuses that are being perpetrated. If we can spot some characteristics, some profiles of abusers, we can institute those as edits in the system. Now, some of them exist already, and where they are used, that is very useful; but we need more.

Senator COLLINS. Are repeat offenders a problem in this program? Is it easy for an individual to simply go out of business in one State and show up in another State as a home health care provider, for example?

Mr. MANGANO. Once a provider is convicted of something criminally, we will exclude them not only from Medicare, but from all other Federal health care programs. They have to spend at least 5 years outside the program depending on the period of time that we exclude them. Then they can come back into the program, and there is no prohibition against them.

Even though people have been excluded, we have found instances where they actually have come back into the system in another State, and maybe the Medicaid agency in a new State did not realize that these persons have been excluded.

I mentioned earlier the problem we have when people get in trouble with us, then transfer the business to a relative or a friend, but actually, they are still running the business. Those are the kinds of problems that exist out there.

Senator COLLINS. One final question for you, Mr. Mangano, and it deals with the unpublished audit that several of us have referred to and that was reported in *The Wall Street Journal.*

In the staff briefing, the Inspector General's office indicated, as I mentioned in my opening statement, improper payments are higher than expected—perhaps 14 percent, or $23 billion—a really staggering figure. All of us in the Senate this week have been debating fundamental changes in Medicare program in order to restore the fiscal solvency of the program. It is very disturbing for us to make tough decisions to, for example, means-test the premiums paid by elderly beneficiaries when we are losing $23 billion a year in waste, fraud or abuse.

Could you tell us, first of all, what you mean by improper payments? How is that term defined? Also, when this new audit will be publicly available?

Mr. MANGANO. In answer to the last question, we will complete the review probably around the middle of July and actually issue a final report.

What we are talking about in that $23 billion is anything from mistakes of the provider in terms of how they billed the product all the way up to fraud and abuse. But every one of these claims should not have been paid. Where there is an underpayment, we take that into account, along with overpayments.

These are the net results of improper payments. This could be like a physician who billed for something by mistake but actually did not provide it. When we went back to check the record, the physician realized he made a mistake and said, "No, I should not have submitted the bill."

For our sample, Medicare is going back and collecting the money that was misspent during this time frame. It is everything from mistakes all the way through fraud and abuse.

Senator COLLINS. It is, in any event, a staggering estimate, and we look forward to working with both of you as our investigation continues. We are trying to get a handle on not only the scope of this problem but, as Senator Glenn and others have stressed, the solutions for it.

I want to thank you very much for your testimony and cooperation with us this morning.

I will now ask our next panel to come forward. The next panel of witnesses includes Leslie Aronovitz, who is currently the manager of GAO's Chicago field office and Dayton sub-office. With a combined staff of 120 evaluators, these offices conduct studies in a variety of civilian and defense programs. Ms. Aronovitz also serves as the associate director in the health financing and systems issues area, where she directs research on a variety of health issues. That is obviously of particular interest to the Subcommittee.

We will also be hearing today from Professor Pamela Bucy, who is the Bainbridge Professor of Law at the University of Alabama Law School, and who has written a number of articles on health care fraud. Prior to joining the world of academia, Professor Bucy was an Assistant U.S. Attorney for the Eastern District of Missouri, where she established and served as coordinator of the Health Care Fraud Task Force.

We are particularly pleased that both of you were able to juggle your schedules and accommodate the Subcommittee's need to postpone the hearing yesterday.

Again, pursuant to Rule 6, I am going to ask you to stand and be sworn in. Do you swear that the testimony you will give to the Subcommittee will be the truth, the whole truth, and nothing but the truth, so help you, God?

Ms. ARONOVITZ. I do.

Ms. BUCY. I do.

Senator COLLINS. Thank you.

Again, because of the time restrictions, I am going to ask each of you to limit your oral testimony to 10 minutes, but I will assure you that your testimony, which in both cases is excellent and extensive, will be made part of the Subcommittee record.

We will start with you, Ms. Aronovitz, please.

TESTIMONY OF LESLIE G. ARONOVITZ,[1] ASSOCIATE DIRECTOR, HEALTH FINANCING AND SYSTEMS ISSUES, HEALTH, EDUCATION AND HUMAN SERVICES DIVISION, U.S. GENERAL ACCOUNTING OFFICE

Ms. ARONOVITZ. Thank you, Madam Chairwoman.

I am pleased to be here today to discuss the problem of fraud and abuse in the Medicare program. At the risk of repeating points from other witnesses, I will try to be brief and highlight a few important issues.

Medicare is an inherently high-risk program because of its size, complexity and rapid growth. In addition, HCFA's efforts to fight Medicare fraud and abuse have not been adequate to prevent substantial losses because the tools available over the years have been underutilized or not deployed as effectively as possible.

Let me discuss a few examples which illustrate my point. First, I am going to talk about funding for program safeguards. Due to budget constraints, the number of reviews of claims both on the Part A and Part B side have dwindled significantly.

Let me focus your attention on our first graphic showing the declining rate of claims reviewed since 1989. As you can see, while the volume of claims has increased to over 800 million in 1996, the actual number of claims reviewed has stayed relatively stable, so the effect is that the percentage of claims being reviewed is now down to about 9 percent as compared with 1989 when about 17 percent of claims were reviewed.

As others have indicated, the deterioration of Medicare's controls over home health payments also exemplifies the effect of the inadequate funding of payment safeguards. As noted on our second graphic, between 1988 and 1996, Medicare spending for home health grew from $2.1 billion to $18 billion, and by the year 2000 is projected to exceed $21 billion. Along with increasing expenditures, the number of home health agencies has also increased from about 5,800 to over 9,000. However, as we reported in 1996, Medicare's review of home health claims plummeted from 62 percent in 1987 to 3 percent or less in 1996, despite the dramatic rise in home health care expenditures.

Independent of the question of adequate funding is the issue of whether available safeguard dollars are being used as effectively as possible. HCFA has not taken full advantage of the controls contractors could use to screen for inappropriate claims. One chronic problem is that HCFA has not coordinated contractors' payment safeguard activities, and as a result, the opportunity to avoid significant Medicare expenditures has been lost.

Let me focus on my third graphic, which shows that many contractors do not screen claims for costly services. In 1996, we reported that of the 29 contractors processing Part B claims in 1994, 17 of them—only 17—could give us information identifying their medical policies and the pre-payment screens they used to ferret out obviously inaccurate claims.

Of the 17 contractors, only 41 percent screened for echocardiograms, despite the fact that Medicare spent $850 million that year for that one test. If you look down the list, less than 50 percent of

[1] The prepared statement of Ms. Aronovitz appears on page 85.

the contractors that we studied had prepayment screens for Medicare's most common and costly services.

Let me give you an example for an eye exam claim. If a contractor had a medical policy explaining under what conditions an eye exam would be acceptable, a claim would come in, and the diagnosis should match or in some way justify that particular claim. We found cases where a claim for an eye exam was justified by a diagnosis of indigestion or something that silly. So there is a tremendous opportunity for contractors to better screen the claims and develop medical policy, because until you develop a medical policy, you cannot enforce it with a prepayment screen.

In addition to HCFA's management of its claims processing controls, its automated information systems have been unsatisfactory. As a result, Medicare's information systems and the staff monitoring claims have been less than effective at spotting indicators of potential fraud, such as suspiciously large increases in reimbursements over short periods of time, improbable quantities of services claimed, like the $5,000 claimed for bandages for a 3-week period of time for one nursing home resident, or duplicate bills submitted to different contractors for the same service or supply.

The system that HCFA is trying to develop would combine Part A and Part B and, as Mr. Mangano said, a very important feature would be that all the claims submitted on behalf of a particular beneficiary would be in one place, and it would be a little bit easier to be able to determine whether those claims were justified.

However, because of acknowledged system weaknesses, HCFA is in the process of acquiring this new, multi-million-dollar automated system, which is intended to replace Medicare's multiple automated systems and enhance significantly its fraud and abuse detection capabilities. However, HCFA has not effectively managed the process for acquiring this system. Now, schedule delays and growing cost projections from a $151 million estimate in 1992 to about a $1 billion estimate this year have forced HCFA to halt much of system's development while the agency reassesses its acquisition plans.

Finally, less than adequate oversight has also resulted in little meaningful action taken against Medicare HMOs found to be out of compliance with Federal law and regulations. This is an important area that I would like to talk about a little bit, because it has not really been mentioned heretofore.

Many people feel that the problems associated with fee-for-service claims are ameliorated when you go to HMOs. However, HMOs in the risk contract program brings its own set of vulnerabilities and concerns that we have done some work on and are very concerned about.

Other than requiring corrective action plans, HCFA has not sanctioned poorly performing HMOs using the tools it already has. These include excluding noncompliant HMOs from the program, prohibiting continued enrollment until deficiencies are corrected, or even notifying beneficiaries of the HMOs cited for violations.

Accumulated evidence of in-home sales abuses coupled with the high rates of rapid disenrollment for certain HMOs also indicates that some beneficiaries are confused or are being misled when they enroll and are dissatisfied once they become plan members.

In addition, consumer information that could help beneficiaries distinguish the good plans from the poor performers is not made publicly available.

Senator COLLINS. Excuse me. I am going to have to interrupt you so we can take a very brief recess until Senator Glenn returns; then he will resume the hearing, and I will return from the Senate floor as quickly as I can. There are only 4 minutes remaining for the vote.

I apologize for having to interrupt, but I am sure Senator Glenn will be back shortly, and he will preside until I return.

Thank you.

[Recess.]

Senator COLLINS. The Subcommittee will come back to order.

We will catch our breath while Ms. Aronovitz completes her statement. Thank you.

Ms. ARONOVITZ. Thank you.

I was talking about the chart that you see here, although I know it is very tough for you to see, and I will try to describe it.

It shows that in 1995, the disenrollment rates—and we are talking about HMOs in the Medicare program risk contracts—the disenrollment rates of Medicare beneficiaries in various HMOs in Miami. As you can see, the percent of members disenrolling in a single year, 1995, ranged from about one in ten to about one in three for different HMOs within the same market. Although there may be several explanations for this, this type of information would certainly be valuable to beneficiaries in their ability to make more informed choices about competing plans. That information is not routinely disseminated to beneficiaries, and instead, they have to on their own obtain information from all the plans, try to see if they can get some consistency in the plans, and try to compare on their own. It is a very arduous and long and involved process.

You have heard about recent proposed legislation, chiefly, the Kassebaum-Kennedy legislation and the budget reconciliation legislation currently being considered by the Congress, that would refocus attention on various aspects of Medicare fraud and abuse. The implementation of the enacted provisions, such as the additional funding for special anti-fraud initiatives and the promise of proposed legislation such as the authority to prevent all convicted felons from being Medicare providers, offer the potential to reduce Medicare losses attributable to unwarranted payments.

But there must be judicious changes in Medicare's day-to-day operations involved HCFA's improved oversight and leadership, the mitigation of system acquisition risks and HCFA's appropriate application of new anti-fraud and abuse funds to reduce substantial future losses.

Moreover, as Medicare's managed care enrollment grows, HCFA must work to ensure that beneficiaries receive sufficient information about HMOs to make informed choices and that the agency's authority to enforce HMO compliance with Federal standards is used. To adequately safeguard the Medicare program, HCFA needs to meet these important challenges promptly.

How HCFA will use the funding and authority provided under the Kassebaum-Kennedy Act to improve its vigilance over Medicare has not yet been determined. The outcome is largely dependent on

how promptly and effectively HCFA implements the Act's provisions.

As we have highlighted today, weak monitoring, poor coordination and delays have characterized HCFA's past efforts to oversee fee-for-service contractors, the system acquisition process, and Medicare managed care plans. Thus, even with the promise of the Kassebaum-Kennedy Act and the potential enactment of additional legislation, the prospects for HCFA's success in combatting Medicare fraud and abuse remain uncertain.

Madam Chairwoman and Senator Glenn, this concludes my prepared remarks, and I would be happy to answer any questions.

Senator COLLINS. Thank you very much.

Professor Bucy.

TESTIMONY OF PAMELA H. BUCY,[1] BAINBRIDGE PROFESSOR OF LAW, UNIVERSITY OF ALABAMA SCHOOL OF LAW

Ms. BUCY. Madam Chairwoman, Senator Glenn, I appreciate the opportunity to be here, and I applaud this Subcommittee's attention to the issue of health care fraud in the Medicare program.

I would like to touch on three themes, two of which have been discussed somewhat here. The first is that if we really want to do something about health care fraud, we must make systemic changes in the payment system. That is really the major way to affect health care fraud.

The second theme I would like to address is privatizing the fraud cops; how do you marshal the private resources that are out there to detect fraud.

The third thing that has not yet been mentioned but I would like to touch on is the danger of overcriminalization.

Last, if I have time, I would like to touch on fraud that will occur as we move more toward a managed care reimbursement system.

First, systemic changes in the payment system. As a prosecutor I often felt like indicting HCFA. It was difficult to understand why the payment system worked as it did. There have been very, very good suggestions here, and I would echo a couple of those.

First, the billing system has to be simplified. Subtitle F of the Health Insurance Portability and Accountability Act (HIPAA) actually directs HCFA to do this, but it gives HCFA 18 months to do it. That is not realistic. Nor should HCFA be allowed to take the 16 years that it has apparently taken on a recommendation made by this Subcommittee in 1981. But that would be the primary thing that could be done to affect the amount of fraud and abuse that is going on.

Second, we should have stronger credentialing of health care providers. There are horror stories about the quality of some of the providers entering the health care field. Some are in the written statements by witnesses today. Three things ought to be examined in credentialing health care providers. First, the training of the people who are providing the services. Second, the fiscal viability of the entity that is providing the service, to make sure it is not going to go belly up or that it is not on shaky ground. Often, a legitimate provider can turn to fraud because it just does not have

[1] The prepared statement of Ms. Bucy appears on page 107.

the financial resources to do what it has undertaken. Third, every health care provider ought to demonstrate that it has a plan in effect to monitor the fraud internally; a compliance plan.

The third systemic suggestion I have to ensure that the new army of "fraud cops" are adequately trained. As I think both of the gentlemen on the last panel testified, there are tremendous resources going into health care fraud prosecution. I have two stories about cases with which I have been involved that demonstrate why it is essential that we adequately train the army of health care fraud investigators and prosecutors that HIPAA has mobilized.

The first case is one that I was involved with when I was a prosecutor in St. Louis. It involved an obstetrician who was also a cocaine addict, who had cash flow problems. When he was running out of money, he would go through his patient files and see who was a few weeks, maybe 5 or 6 weeks away from her delivery date. He would call them up and say, "I have been reviewing your file, I see some complications, and you need to come on in and let me deliver that baby." None of it was true; there were no complications.

Well, we prosecuted him and convicted him for felonies. Not only was he hurting his patients, but he was doing every kind of billing fraud you could imagine. He was upcoding, he was billing for services that he was not providing, and he was billing for unnecessary services.

He was convicted of felonies, he was excluded from the program, and he lost his medical license. And now, with the asset forfeiture, all the eligible assets he had could be forfeited. That is exactly the kind of case that ought to be criminally prosecuted.

The other case that I would like to tell you about is one that involves a physician in upstate New York whose name is Naveed Siddiqi. He is 60 years old. He is board-certified in internal medicine, oncology and hematology. In 1989, HHS opened an investigation on him. In 1991, he was convicted of five felony counts of Medicare fraud. He was acquitted on 72 counts. He was excluded from Medicare for 5 years. He went before the New York Licensing Board. He ended up with only a reprimand; he did not lose his license.

Prior to his conviction, he was making about $825,000 a year as an oncologist. After his conviction, he secured a job at the VA, worked full-time and earned about $80,000—still a good salary, but obviously substantially less than he was making.

In 1996, on Halloween of last year, the Second Circuit on Dr. Siddiqi's habeas corpus petition, set aside his conviction. The court said that his trial had been a "trial by ambush"; the Court said that it was setting aside his conviction because it had been a miscarriage of justice. Dr. Siddiqi had billed for two patients who received chemotherapy while he was out of the country. Now, that looks like pretty blatant fraud. I can tell you as a prosecutor that I would have looked at that, and I would have thought: This is pretty blatant fraud.

Dr. Siddiqi submitted a billing code of 96500. Code 96500 allows billing for "supervising the administration of chemotherapy." And as the Second Circuit went through in its opinion, the prosecution never understood what 96500 meant. The prosecution constantly

changed its theory of the case as the trial went on. The prosecutor said that Dr. Siddiqi had billed for administration of chemotherapy when he did not provide it. The prosecutor said that Dr. Siddiqi had double-billed. Finally, the prosecutor argued, well, he did bill for supervision, but he did not supervise.

Part of what the Siddiqi case demonstrate is why we need to have simplified billing—there were eight different sources of what 96500 could mean. The Second Circuit concluded that it was very clear that 96500 was ambiguous. It also concluded that was probably OK for Dr. Siddiqi to bill as he did—that was all they could say—because he set the dosage amount before he went out of town. These were patients who had to have their chemotherapy while Dr. Siddiqi was out of the country. I am not an oncologist, but from what I understand, to set the dosage amount of chemotherapy requires extensive testing of the patient and calibrating the amount of toxin that you are going to give to the patient. Dr. Siddiqi set that amount after evaluating the patients, and he arranged for a physician to cover for him and gave the physician directions for what to do. So in fact, if that is supervision, then he had supervised.

I think these two cases show two things. First, there are bad health care providers out there, and when we find them, we need to throw the book at them—the obstetrician in the first case is exactly the kind we should vigorously prosecute.

The other thing that these cases show is that health care fraud is very difficult to prosecute. Something that looks like blatant fraud may not be. It takes a tremendous amount of understanding about billing codes and a good sense of what is criminal and what is not, to distinguish a crime from an error.

The cost of the Siddiqi case is not just the cost to Dr. Siddiqi, but it is the cost of wasted resources. The prosecution and judicial resources that went into prosecuting Dr. Siddiqi should have gone to something else, and they did not; they were wasted.

Also, an unfair prosecution hurts the criminal justice system. People look at it and ask, what has gone on here—are the prosecutors nuts? It cheapens the entire criminal justice system to have a prosecution of non-criminal acts.

Thus, the third suggestion I have, in terms of just systemic change is to train our new army of prosecutors and investigators so they know what is fraud and what is not.

Now, in terms of privatizing the effort against health fraud, privatizing has tremendous advantages. Obviously, it does not take government resources; it does not cost the government anything. The qui tam provisions which were tremendously enhanced in 1986 have had a very interesting development; they have created a group of expert private fraud cops. There are law firms out there that have outstanding talent to ferret out fraud and prove it. There are accounting firms that are able to do that. Those resources ought to be marshalled better in the fight against health care fraud. I have a couple of suggestions on how to do that.

First, there has already been discussion of the role of the carriers and the intermediaries. In my opinion, carriers and intermediaries have no business being fraud cops; they should not have the responsibility of examining their claims for fraud. They get paid for

the number of claims they process. If they do a very good job of processing their claims, they are not going to be able to look for fraud. For this reason, they have an inherent conflict of interest.

Second, when carriers and intermediaries do find fraud, look what it tells us about how they have been processing their claims—that they are doing a poor job of it. Furthermore, the more fraud they find, the more obvious it is that they have been doing a bad job of processing their claims.

The third thing is that for carriers and intermediaries to have their contracts renewed as carriers and intermediaries, they have to show that they have a viable fraud detection program. Well, when they want to cover up the fact that they do not have a fraud program, you have more fraud. Blue Cross/Blue Shield of Michigan, for example, just paid a $27.6 million settlement because it concealed its bad efforts in detecting fraud.

In summary, my first suggestion of privatizing the fight against health care fraud is to take away the fraud detection obligation from the carriers and intermediaries and give it to private entities which are qualified to do it.

Now, the Health Insurance Portability and Accountability Act, (HIPAA), which just passed, provided that HCFA can contract with eligible entities to provide this fraud detection services, but it also provided that the carriers and intermediaries are deemed to be eligible entities to do this. I think the presumption ought to be opposite—that carriers and intermediaries are deemed to be ineligible entities because of this conflict of interest.

I see that my time is about up, so I will touch on one of my remaining suggestions quickly. RICO ought to be amended to include the new criminal offenses that are in HIPAA so that they will be RICO predicate acts. This will permit greater use of civil RICO for class actions. That is a good way to mobilize the private bar.

My written materials cover the rest of my suggestions.

Senator COLLINS. Thank you very much. Both of your testimonies were very helpful to the Subcommittee.

Ms. Aronovitz, I want to follow up on something the professor just said. She said that the fiscal intermediaries have "no business being the fraud cops, that there is an inherent conflict." First of all, do you agree with that statement, and if you do, who should have this responsibility, and how can we get a handle on this?

I was very concerned about the chart that you showed where the number of claims filed is over 800 million, and the percentage review has dropped, I believe, 9 percent. It has dropped substantially. So whose job is it? Who can most effectively do this job?

Ms. ARONOVITZ. I think that whomever can do it needs to do it. Mr. Mangano was talking earlier about the fact that right now, contractors have to do many things, and they get paid to do many things, but their most important responsibility is to process claims and do it quickly.

Once they do that, they also have responsibilities to do safeguard activities, and there is a lot of discussion about their ability to do that well. And I think some contractors that we visited do a wonderful job in certain areas, so in our opinion, it is not across the board that they should be excluded except for the fact that they do not have the same incentive right now or, admittedly, the same ex-

pertise as they do in their first job, which is to process claims, to do safeguard activities.

I think the Kassebaum-Kennedy Act, which gives HCFA the authority to contract with separate utilization review companies for safeguard activities is a really good step. I think Professor Bucy would say that fiscal intermediaries and carriers should not even be qualified to be able to do that. I do not particularly have an opinion on that except that if they did get that separate contract, they would have to prove to HCFA that they had the expertise and the will to do a good job. Currently, the funding for safeguard activities has gone down per claim. They have a lot less money now per claim to do safeguard activities, and it has taken the back burner to their claims processing activities.

Senator COLLINS. Professor Bucy, I appreciate the fact that you gave us two examples in your testimony, one of clearly fraudulent activity and the other where it was eventually found that it was not a case of fraud.

One of the issues that I was discussing with Senator Glenn on the way back from the last vote is that we have this massive number of improper payments made each year, amounting to $23 billion. We are trying to determine if some of these improper payments are being made by providers who are honest but who do not understand the regulations or the paperwork. In other words, are there some honest errors that are being included in this figure?

Based on your experience, could you comment—and actually, I would like to hear from both of you on this issue—on how much of a problem you think can be attributed to a lack of understanding by providers, or to the complexity of the regulations? Or do you think the problem is mainly one of true waste, fraud and abuse?

Ms. BUCY. I think there is an awful lot of misunderstanding. I think some of the national initiatives, like the 72-hour DRG initiative and the PATH initiative, are running into that problem, that basically, what they are calling "abuse" has been done by everybody, based upon fairly ambiguous regulations. So how can you say that is fraud?

So yes, there is a lot of honest misunderstandings, even sloppiness; not all billing errors are fraud. I do think that if Subtitle F of HIPAA goes into effect, and there is administrative simplification, a lot of the misunderstandings will wash out of the system, and we will no longer have to have this debate about how much is just an honest misunderstanding because of ambiguous regulations. And I hope that will be done because that ought to be out of the debate.

Senator COLLINS. Ms. Aronovitz.

Mr. ARONOVITZ. I think there is a lot of discussion about the complexity of program rules, and that is absolutely true—they are very complex, and depending upon how you bill and under what conditions you are supplying a service, it could get somewhat confusing in terms of how you could properly bill.

There is a lot of discussion that these program rules inhibit more aggressive enforcement because you have that exact excuse, that I made an honest mistake, I had no intention of hurting or ripping off the system. However, it is very, very frustrating to find providers who repeatedly, over and over again, commit the same bill-

ing errors and the same "mistakes" without ever having to answer to any kind of justification.

We have seen, for instance, in the home health program, when the regional home health intermediaries asked for documentation to support a particular claim or set of claims, that very often the home health agency will not even submit the documentation because in their minds—I do not know exactly what is in their minds—but what we see is that it is probably cost-effective for them to have those particular claims disallowed as they continue to bill the program for additional and future claims.

So if you have repeated billing problems of the same type, and you have a total lack of fear about anything happening to you in this program, it is very, very hard to imagine that this is totally an accidental mistake. So we do worry about this a lot.

Also, one thing that we have been thinking a lot about to remedy this is that providers should be held responsible for subsequent mistakes that they make. So that if you could manage to measure the cumulative problems that somebody has, if in fact they make a mistake the first time, and let us say 2 or 3 percent of their claims that you looked at were bad, but then this continues to happen, and their cumulative mistakes add up, then you could say, look, you are no longer exempt because you say you are confused; you clearly have been educated, and now it is time to do something to either exclude you or to take more drastic action. And that is not typically done at all.

Senator COLLINS. Thank you.

I am, unfortunately, going to have to go vote again, but Senator Glenn should be back in just one moment. Let me give you a question to think about during the brief recess. With Medicare moving more from a fee-for-service system to a managed care system, some have said that will reduce the ability of providers to engage in wasteful practices or outright fraud because of the incentives in managed programs. Others have said it will just create new opportunities. And while I go to vote, I would like you both to think about that question so that we can pursue it when I return.

Thank you. We will take a brief recess.

[Recess.]

Senator GLENN [presiding]. We will reconvene the hearing, and I apologize for the inconvenience.

You say there has been pretty good progress made in improving Medicare integrity—or that is one of the statements that has been made—yet we see that the estimate of the Medicare payments procured through fraud and abuse has gone from about 10 percent up to 12 percent, and that comes to about $23 or $24 billion worth of money here. How are we measuring this? Are we measuring better so the fraud is going up, or are we really making progress? We cannot be making progress and still have the percentages going up. What is your estimate on that?

Ms. ARONOVITZ. We have been estimating that from 3 to 10 percent would be attributable to fraud and abuse in the health care system, and you could then extrapolate that to Medicare. That is an estimate.

I am not that familiar with the OIG report since it has not been issued yet, but from the articles that I have read, I have noticed

that their methodology includes amounts or claims that in fact should not have been paid. But the reason why those claims should not have been paid has not been actually identified, so in fact some of those could be mistakes or unintentional errors or lack of documentation where, if documentation could be obtained, then there would be—so it is hard to really compare those two numbers until we know more about what the OIG study says.

Senator GLENN. The Health Insurance Portability and Accountability Act that was passed last year is a rather complex thing in some ways—Jeff, you have done a lot of work on that, so go ahead and ask a question on that.

Mr. ROBBINS. The Department of Justice Health Care Fraud and Abuse Control Program and Guidelines which were approved in January of 1997 by Secretary Shalala and the Attorney General set forth a series of relatively uncontroversial goals for a coordinated health care fraud and abuse program, and among the goals with which nobody can take issue are "coordinating Federal, State and local law enforcement efforts, conducting investigations, audits, evaluations," and so forth, "facilitating the enforcement of all criminal, civil and administrative statutes, providing industry guidelines, and establishing a national databank."

So the question that occurs is where the problem of massive waste, fraud and abuse is not a new one, these would not seem to necessarily represent fresh new ideas however laudable they are.

What, therefore, I wonder if you can tell us, is the substantive difference that you expect under the HIPAA-mandated program, and what is the difference between what has been mandated under that program and what has been tried before without apparently making a significant dent in the amount of health care money lost to fraud and abuse. And second, I think in the GAO statement at page 8, there is a reference to an annual evaluation of the program's effectiveness. I wonder if there is in place a set of specific, concrete, meaningful measuring tools that you expect of the GAO to hold the program up to every 12 months or so in order to test in a meaningful way whether the program is achieving real results. If so, what are those measuring tools?

Ms. ARONOVITZ. We are in the process—actually, we have been mandated by Congress to evaluate the implementation of HIPAA by all the parties, and we are in the process of developing a methodology to do that. So we are not yet in a position to be able to state exactly how we are going to go about measuring that. But one thing that we are very concerned about, which gets to your first question, is the actual implementation of some of the programs that are now being discussed.

In Operation Restore Trust, which you are all probably very familiar with, the OIG and HCFA and the Department of Justice and others have talked a lot about some of the successes in that program and how they were able in five States to do a very focused effort to try to look at fraud in the DME, nursing home and home health areas.

But what has been interesting is that one of the biggest things that comes from ORT is the fact that up until that point, there was not a lot of coordination between different law enforcement entities, so that in fact even though it might sound very strange, there was

not a lot of coordination between what was happening in the OIG and also in the Department of Justice, where they would get together and share information and work on cases together. The State is asked in the home health program to certify home health agencies; they typically look at the conditions of participation, which deal very strongly with quality issues. However, the certification people were not that well-trained to be able to identify potential overpayments or billing errors or coverage problems or whatever, and now they are beginning to learn how to do that, so they will then be able to go back to the home health intermediaries and say, you know, we went out on the certification, and we have a concern about this home health agency; you might want to look at it from a fiscal standpoint.

So one of the things that is very interesting is that some of these efforts that are being announced have not been all that well done in the past, and now, hopefully, because it is considered to be a project that is well-funded, and we will be evaluating it, we are hoping that some of these projects will get implemented more completely—and that pertains to some of the other projects that you mentioned also.

Mr. ROBBINS. Ms. Bucy.

Ms. BUCY. I do not think HIPAA goes far enough. I can give you several examples. First of all, HIPAA does give HCFA the authority to contract with "eligible entities" to serve as fraud cops on the Medicare claims, but it also "deems" the carriers and intermediaries to be eligible entities. So I would change that presumption so they are deemed to be ineligible entities.

Second, I do not think the forfeiture provision that was added to the criminal provisions goes far enough. Section 249 allows for forfeiture of proceeds of the fraud and property that has been involved in the fraud. It does not allow for forfeiture of property that has facilitated the fraud, which some of the forfeiture statutes do.

In addition, the new criminal offenses that were created are not made predicate acts under RICO. I think this is a serious omission which limits RICO's use by private attorneys in class actions or other civil RICO lawsuits.

Lastly, qui tam provisions should be expanded to include the anti-kickback statute, and that was not added.

So I do not know that there is everything that ought to be in HIPAA.

Senator GLENN. Thank you.

Professor Bucy, you have written—and I gather you have written this in a number of Law Review articles also—you make some interesting recommendations. One of them is to require Medicare providers and Medicaid providers as well to certify that they have provided all necessary services. In other words, they have certain responsibilities, and I guess it is your feeling or your experience that they have not lived up to these things and that they should be prosecutable as well for not living up to this. This is particularly important as we move into more of a managed care thing, with HMOs and so on. Is this a major problem now that they are making their money, or is fraud just by under-providing and saving money and not providing services—I would think that would be

much harder to define and to get at than just mispricing of certain pieces of equipment.

Ms. BUCY. You are exactly right, it will be hard to prosecute. My suggestion is to make prosecution easier when it is appropriate. And again, I have concerns about overcriminalization. But as we move to managed care, which uses a capitation type of payment, providers lose money if they provide too many services. So that obviously, there is a financial incentive to underprovide services.

If there is a certification, say, annually—I think the best way to do it would be annually, at the end of the year—by HMOs, whether they are Medicare, whether they are private pay, whatever—that certifies that the HMO has provided all necessary services, a prosecutor can go back, show a sufficient pattern of underutilization. The certification becomes the false statement that the HMO can be prosecuted for.

Certification, may of course, remind providers of their obligation, but it also will make prosecution of appropriate cases easier, because then you have a false statement.

Senator GLENN. Do you need additional legislation, or do current laws cover that?

Ms. BUCY. Current laws would certainly allow for prosecution once you show a pattern of underutilization; that would be a scheme or artifice to defraud to fail to provide the services that as HMO is contracted to provide. But it is difficult to prosecute as an implicit obligation. It is much easier if a prosecutor can go in, present a piece of paper that says, "I certify this," and that is signed by somebody. So it would make the prosecution easier in those egregious cases, and I think it should be reserved for the egregious cases. That is why I think a certification would be helpful.

Senator GLENN. I would think that would be covered now. Most of these places have to be licensed, anyway. I guess everybody has to be licensed by the State, do they not?

Ms. BUCY. The HMO providers do, but the licensing is not standard, and to my knowledge, there is not a certification when you are qualified, say, as a Medicare HMO, that says we have provided all necessary services.

Senator GLENN. But there would not be a presumption that just because people are in that particular business that they would have the responsibility to provide the minimum services of that business?

Ms. BUCY. There would be that implicit presumption, but what I am saying is that to prosecute somebody, it will be helpful to have an explicit certification. It would be exactly like the Form 1500 where providers certify that they have provided all medically necessary services.

Senator GLENN. It is my understanding that since 1994, HCFA has revoked approximately 1,500 billing numbers for providers. Is that a tough process? Is that very difficult to do?

Ms. BUCY. I think HCFA would be able to tell you that better than I.

Senator GLENN. OK. Have you looked into that, Ms. Aronovitz?

Ms. ARONOVITZ. Yes. We have done some work where we have looked at the process that HCFA would have to go through to ex-

clude a provider, and it is a very arduous process, and it is also one that the OIG has a major role in and needs to do a much better job. A lot of it has to do with obtaining information from the States about Medicaid providers that have been excluded by the States and even taking that information and passing it along to the HCFA regional offices and then to headquarters, so that action can be taken on those same providers.

What we found in our last study was that very often, a provider could be excluded from the Medicaid program and still be billing Medicare, because there was not good enough communication, and the program was not working well enough. When you are excluded from any Federal health program, you are excluded from all of them, and that communication is something that is very tricky and was not very well done, and it is something that we are still concerned about and will continue to look at.

Senator GLENN. Just one additional question, Madam Chairwoman, if I could. Across the board, do we need to do anything in legislation to help get into this area? Is it mainly a matter of money and putting more money into enforcement and so on? Do we have all the laws on the books that would enable us to really get at this thing, or do we need some additional legislation?

Go ahead, Ms. Aronovitz.

Ms. ARONOVITZ. I think there are always aspects of legislation that could be useful. As a matter of fact, I am thinking of one particular situation that would require congressional consideration, and it has to do with the home health agencies. It was a report that we issued to Senator Harkin last week about ways that you could assess home health agencies once they have proven that they are abusive billers to have to pay or contribute to the cost of doing a more comprehensive study on those agencies if they want to stay in the program.[1]

There is legislation that we could talk to you about that would help, but what I always get back to and what is very disconcerting to me is that we feel that there is still a lot that HCFA could do within the money they already have and within the regulations and law that already exists.

And I think that until we get to a point where HCFA takes the opportunity and shows the leadership to assure that there is a comprehensive strategy for monitoring claims processing, that HCFA makes sure that its acquisition system is properly obtained and built and designed, and that other kinds of actions are taken, that they use the tools of enforcement that they already have to enforce some of the problems that we have noted over and over again, it is hard for me to assume that more money and more legislation would be the answer.

Senator GLENN. OK. We might want to have staff work with you, and you ideas might help in some legislation in this area.

Ms. ARONOVITZ. Certainly.

Senator GLENN. Ms. Bucy.

Ms. BUCY. I would echo what Ms. Avonoritz has said, that right now, there are more than enough resources, and we just need HCFA to do a better job with the resources. In addition to the com-

[1] The GAO Report referred to as Exhibit No. 3 appears on page 180 in the Appendix.

ments that I have already made about increasing the forfeiture authority, adding the HIPAA new offenses as predicate acts to RICO, adding qui tam to the anti-kickback statute, and making sure that carriers and intermediaries cannot serve as "fraud cops" claim they process, I would suggest that the qui tam False Claims Act provisions be amended so that government employees are not eligible to serve as relators when the fraud deals with their particular duties. I think that is an issue that has been brought up numerous times before Congress.

I would suggest that the standard for corporate criminal liability needs to be addressed by Congress. It has been formulated by the courts. It is much too broad. I think it is a good example of allowing overcriminalization. We need to be able to prosecute corporations, but under a more reasonable standard.

I suggest that main justice should be required to approve all investigations of publicly held companies. This would be across the board, whether for health care fraud or any white collar crime. The experience with Columbia HCA, whose stock plummeting with the recent investigation in Texas—and the investigation may be completely warranted, and I am not getting into that—but just in the instances where that may not be the case, I think that shareholders deserve that kind of protection.

The last thing—and I believe there is some leadership from this Committee on this already—is to make sure that we have ways of monitoring the quality of HMOs. This is where we will see abuse and fraud in the future. We need enlightened taxpayers who are able to judge the quality of HMOs. This will be increasingly important as we switch more to a managed care system.

Senator GLENN. Thank you, and we hope that maybe you would be willing to work with staff on this if they contact you for your ideas in this area. We would appreciate it very much.

Thank you, Madam Chairwoman.

Senator COLLINS [presiding]. Thank you, Senator Glenn.

Your final statement, Professor, brings us full circle back to the issue I raised before I had to go vote. I would like each of you to comment briefly on whether you do see a potential for different kinds of fraud or increase fraud as we move from a fee-for-service environment in Medicare to greater use of HMOs.

Professor, perhaps you would like to expand a little bit on what you were just saying.

Ms. BUCY. There will continue to be fraud in health care. There will be different kinds of fraud because the financial incentives for the types of fraud will change as the method of payment changes. But I think we are fortunate in the sense that some of the States have had experience with managed care already including experience with fraud. Some of these States have already developed, on a smaller basis, the systems that will work as managed care expands nationwide.

For example, there will be an incentive to enroll fictitious employees once we have managed care, and Arizona, in particular, has developed some good methods for handling this problem. Medicare could use Arizona's model.

False cost reporting is another example. This type of fraud will be an issue in managed care. As long as we set capitation rates

based on cost, there will be an incentive to falsely inflate costs. To counteract this, I would suggest that all cost reporting entities be required to hire independent "fraud cops." Certification of accurate cost reporting by an independent auditor who is familiar with health care fraud would go a long way in deferring and detecting false cost reporting. False cost reporting is one of the most difficult types of fraud to detect and prosecute, so to try to prevent it up front by having a good audit done by outside folks would be helpful.

Also, with managed care marketing scams are going to increase. There is current authority to prosecute these scams, but the "pay and chase" approach is not helpful. What we really need are preventive measures. Further education of Americans will help prevent marketing scams as will collecting and publicizing quality control information on HMOs.

There have been instances, especially out in California, of "kiting patients," where Medicaid patients are assigned to an HMO; the HMO delays reporting the patient to the primary care provider. The HMO thereby basically gets a 30-day float where it does not have to pay the primary care provider for taking care of this patient. If the patient needs something in the 30 days, they just kind of get "lost in the shuffle"; otherwise nobody knows the difference, and the HMO gets to keep the amount.

What they found in California is that when the 30 days was up, the HMO would reassign the patient to another primary care provider and get another 30-day float. One HMO had 24 percent of its patients at any one time not registered with a primary care provider.

I think some very simple things could be done to prevent this kind of fraud, such as a certified letter going to the patient indicating that they have been referred to the primary care provider. This would be a copy of the letter that goes to the primary care provider.

To conclude, there will be fraud in managed care. Some of the States, notably Maryland, Tennessee, and Arizona have had a fair amount of experience with managed care and have worked out systems to prevent some of these problems. Consulting their Medicaid Fraud Control Units for guidance would be helpful.

Senator COLLINS. Ms. Aronovitz, in addition to addressing that generally, since this will be my last question, could you also comment on the disenrollment rates, that is whether they are an indicator of where HCFA should look for trouble? I am astonished by a disenrollment rate of more than 35 percent in 1 year. To me, that is a real red flag indicating that there is either a quality or a service or some other problem with the HMO. Please comment on that as well?

Ms. ARONOVITZ. Absolutely, and what you say is exactly correct, and it raises eyebrows to the extent that we feel that something has got to be done to look at those.

In fact, some of the work that we have done—reporting these disenrollment rates, we did have evidence to show that HCFA had a lot of information about violations or quality problems that were occurring in some of the HMOs that have high disenrollment rates. So we think there could be a very close correlation between people

getting in and getting disenchanted for some reason, and then getting out.

But to get back to your basic question, clearly, there will be another whole set of incentives, as Professor Bucy said, when you have a capitation-type set-up. Actually, the temptation could be even greater, because in a provider's case, when they provide an individual service, they might get a certain amount of money for providing an office visit or whatever, but in an HMO, it is so competitive to try to get as many beneficiaries as possible, because for each one you get, you get several hundred dollars from HCFA to cover all the care of that particular beneficiary, and if you do not do a very good job, then you could make a lot of money every month on having these people enrolled.

We have done a lot of work, and I think it is way too complex at this point or at this time in the hearing to talk about it at length, but we would be happy to come and talk to you later, about looking at resetting the proper payment rate for HMOs. Right now, we believe they are receiving too high a capitation rate, and the formula that HCFA uses to try to decide or figure out how much to pay HMOs is too high in terms of what we think the elements of the formula should be; so that needs to be adjusted.

There is definitely a strong incentive to underserve. It would extend to individual physicians who take on some of the risk, who would be paid by the HMO to take on some of the risk and serve a patient. So patients are very vulnerable under this system, and there need to be very strong protections, quality assurance systems that need to be looked at, not just on paper, but actually, people need to go out into the field and make sure that the quality assurance systems and also the process by which people could appeal a denial of coverage or other types of complaints—all those types of issues certainly need to be investigated much more closely, especially when you have information that is occurring.

So there are tremendous vulnerabilities in this approach, and they have got to be dealt with.

The last thing I want to say is that very often, the marketing abuses that we find really come when beneficiaries have no basis to make a selection about what HMO to get into. And right now, HCFA collects a lot of information that would be extraordinarily helpful to a beneficiary to decide what plan to go into.

On this chart, if you wanted to choose a plan just based on this one piece of information in 1995, I think you would probably want to choose one of those with a lower disenrollment rate, just because, without even knowing why, you would think maybe it is a little safer because fewer people are leaving.

So it is those kinds of questions that I think HCFA needs to be more aggressive in helping the beneficiaries work out.

Senator COLLINS. Thank you very much.

I want to thank you both for your testimony and cooperation. We look forward to working with you further on this important issue.

Ms. BUCY. Thank you.

Ms. ARONOVITZ. Thank you.

Senator COLLINS. Our final witness today is Bruce Vladeck, Administrator of the Health Care Financing Administration, or HCFA, which is the agency charged with managing the Medicare

program. Since his appointment by the President in 1993, Mr. Vladeck has been responsible for the delivery of health care services to 70 million Americans who are served by the Medicare and Medicaid programs.

We very much appreciate your being here today. I know it took considerable juggling of your schedule, and we appreciate your efforts.

Pursuant to Rule 6, requiring all witnesses who testify before the Subcommittee are required to be sworn, I would ask that you please stand and raise your right hand.

Do you swear that the testimony that you are about to give to the Subcommittee will be the truth, the whole truth, and nothing but the truth, so help you, God?

Mr. VLADECK. I do.

Senator COLLINS. Thank you.

If you would proceed, we would ask that you attempt to limit your oral testimony to 10 minutes.

TESTIMONY OF BRUCE C. VLADECK,[1] ADMINISTRATOR, HEALTH CARE FINANCING ADMINISTRATION, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Mr. VLADECK. Thank you very much, Madam Chairwoman and Senator Glenn. I am pleased to be here to have the opportunity to talk about our efforts to fight fraud, waste and abuse in Medicare and Medicaid. We have a prepared statement, and I will, in keeping with your suggestion and the other scheduling difficulties we have had today, to try to keep my opening remarks quite brief.

We understand how important it is to our programs and to our beneficiaries that we do everything that we can to ensure the integrity of the program, to make sure that every Medicare and Medicaid dollar is well-spent, and that goals of efficiency and cost-effectiveness do not compromise the quality of health care.

It is also important to emphasize that remedying a very significant and pervasive set of problems that have grown up over a period of years and suffered from years of neglect is necessarily a process that takes time and requires a stepwise set of changes. When I arrived as HCFA's administrator at the beginning of this administration, there was not a single senior official at the Health Care Financing Administration whose full-time job was program integrity activities. Many of the issues that have been identified by earlier witnesses today obviously involve matters that have gone back for quite a number of years.

Since 1993, we have taken a number of new and aggressive steps regarding HCFA's internal organization, the way in which we conduct business, and work with our partners in the Office of the Inspector General, the FBI, the Department of Justice, and the States. Operation Restore Trust, which began in 1995, became the focus for a lot of our experimentation with development of new techniques and new approaches to detecting, combatting and prosecuting fraud and abuse against the programs. We learned a lot in that process. The provisions related to fraud and abuse in the HIPAA, previously the Kennedy-Kassebaum legislation, were large-

[1] The prepared statement of Mr. Vladeck appears on page 154.

ly the result of proposals that we had been making for several years. These fraud and abuse provisions provide us with very important tools and, perhaps most importantly, with new resources in which to pursue some of the problems, which we have identified. In two sets of legislation this year, the President's budget bill and his supplementary anti-fraud and abuse legislation which he announced in March, proposed a number of other specific policy changes growing out of our experience of the last several years. We believe that the President's proposals will contribute importantly to our continuing anti-fraud efforts. We are delighted that, as the reconciliation process has proceeded in both chambers a large proportion of the administration's recommendations and proposals have indeed been incorporated into the legislation, passed by the House and Senate.

Just a few other observations, if I could make them very quickly. The first is that our underlying philosophy relative to fraud and abuse in Medicare and Medicaid should ensure that we need to do as much prevention as possible. This prevention philosophy is also applicable to health care generally. We have to prevent problems from arising, rather than retrospectively engaging in what we have come to call "pay and chase" after the fact when problems emerge.

There are two major components to a philosophy of paying right the first time. The first is identifying policies or problems that are inherently subject to abuse or inherently awkward in a variety of ways. Previous witnesses have suggested a number of examples. The second component involves changing the policy to achieve a number of objectives, such as reducing opportunities for certain kinds of fraud and abuse.

Therefore, this year's legislative proposals involving prospective payment skilled nursing facilities under Medicare require consolidated billing for all ancillary and other professional services rendered to nursing home residents. When implemented, the prospective payment provisions will eliminate a major area that has been identified by the Inspector General as an area of fraud and abuse. This was a subject of the GAO's testimony. Prospective payment for home health care will change very dramatically the issues involved with program integrity.

Similarly, we need the tools, such as competitive bidding for durable medical equipment and other Part B services to drive out the excess profits built into the pricing structures in many parts of the Medicare program which make those services particularly attractive for people whose motives are less than entirely pure. We are delighted that the Senate reconciliation legislation grants HCFA the authority, which we have sought for many years, to use the mechanism of competitive bidding as a way of setting prices for Part B services rather than requiring HCFA to continue to follow very cumbersome payment determination methods that are currently established in statute in excruciating detail.

Finally, I wish to emphasize the administration-wide commitment to anti-fraud efforts. While it may seem to most to be a common sensical approach, how significant a change it has been in the last 3 or 4 years, as one of the previous witnesses suggested, to find an Administration-wide commitment in anti-fraud efforts. For instance, the Attorney General, the Director of the FBI, the Sec-

retary of Health and Human Services, and the Inspector General of the Department of Health and Human Services, and the Inspectors General of a number of other agencies with important health care responsibilities, such as the Office of Personnel Management and the Department of Veterans Affairs, have come together on a regular basis to have a single administration-wide steering Committee on efforts to combat health care fraud and abuse. These entities are sharing a common database about investigations for the first time in history, are exchanging detailed investigative information for the first time, and the benefits of such cooperation have already begun to emerge in identifiable cases, prosecutions, convictions, and exclusions of fraudulent individuals from the program all across the country.

Cooperation among Federal entitles was strengthened by the language in the Kennedy-Kassebaum legislation. This cooperative structure was put into place recently, and we believe that it is going to pay significant dividends in years to come.

That is a very brief summary of much material, and I am obviously happy to answer any questions that you might have about any of these issues, and again, I appreciate the opportunity to be with you today.

Senator COLLINS. Thank you very much.

One of my major concerns, which I know Senator Glenn shares from a conversation we just had, is that the amount of improper Medicare payments are not going in the right direction. They seem to be going up with each new report that we get from the GAO or the IG's office. We now have the latest report, which suggests that improper payments may be as high as 17 percent, annually. The mid range estimate is 14 percent. First, let me ask you whether you agree that the problem is getting worse, and if you do not agree, how do you account for the findings of the GAO and IG?

Mr. VLADECK. I do not agree that the problem is getting worse. I think we do have some evidence that it is getting less bad—I will not say "better," but that it is getting less bad. The study you cite, which was reported in *The Wall Street Journal* and which will be made public in the next month or 6 weeks represents the first ever statistically valid national sample audit of Medicare claims payment. There is no comparable data available historically with which to compare those findings.

All of the other numbers that have been cited before, involving the numbers estimated and the documents from which the figures originate, are recognized to be much rougher estimates based on much less systematic and much less complete data. Therefore, the estimates that will be contained in the Inspector General's audit of HCFA's fiscal year 1996 financial statement is the first time a nationally replicable, statistically valid estimate on Medicare claims has ever been conducted.

Senator COLLINS. I guess I am not comforted by that fact in that this new estimate of fraud is higher than the estimates described in previous studies. This is the first study that shows an improper payment rate of approximately 14 percent. We have a $23 billion problem on our hands.

Mr. VLADECK. We have a very considerable problem. However, consideration of other indicators of changes over time, involving

categories of billings for the Medicare program where HCFA has been most concerned about fraud and abuse and has focused its investigative and other efforts over the last 2 or 3 years, we have found in the last 18 months or so, a significant reduction in the rate of growth of payments for durable medical equipment in Medicare. We would be happy to share the specifics of these findings with the Committee. There has been an actual reduction from 1 year to the next in the dollar volume of laboratory claims which HCFA has paid in certain parts of the country. There has also occurred a significant flattening in the growth of home health care claims. We are seeing changes in the trend line in these areas and jurisdictions in which HCFA has concentrated its investigative and prosecutorial resources. This is why we are seeking to expand these efforts performed over the last 2 or 3 years.

Senator COLLINS. You mentioned durable medical equipment and that you are seeing some progress in that area. I do not know whether you were here earlier when some of the witnesses were doing comparisons of the amount that the Veterans Administration was spending for the same items and citing competitive bidding as the reason for the difference. Has HCFA actually been precluded from using competitive bidding? I understand the reconciliation bill permits you to do so, but in the past have there been legal obstacles to your using competitive bidding to help control the costs of commonly available items?

Mr. VLADECK. Let me be very careful about this because this is very important, and the answer is that except for the possible application of HCFA's demonstration authority on an experimental and trial basis, we have not legally been permitted to use competitive bidding for setting prices for durable medical equipment. The one time in the past in which HCFA publicly announced its intention to conduct a demonstration of competitive pricing for durable medical equipment, we were specifically forbidden by the Congress from proceeding with that demonstration.

Senator COLLINS. From your answer, can I assume, now that Congress is giving you a green light, that you will aggressively pursue competitive bidding in this area?

Mr. VLADECK. Aggressively.

Senator COLLINS. Let me ask you a question about the automated information systems that are being used to process Medicare claims. It is my understanding that HCFA now is in the process of replacing those systems with a single, unified system which is referred to as the Medicare Transaction Systems. GAO, as I am sure you know, issued a report last month which concluded that the success of implementing the Medicare transaction system depends upon HCFA correcting very fundamental managerial and technical weaknesses in the program, and one area that I found particularly troubling was the cost growth in this project.

I know that all of us who have tried to implement new computer systems find that it frequently costs more than we think, but in this case, the estimated cost had increased, I am told, from $151 million to $1 billion. That is a 600 percent increase in 5 years. Could you explain the significant growth in the cost estimate and also give us some update or assurances that these problems are under control, because clearly, if we cannot get an automated sys-

tem that we have confidence in and that works well, that is going to undermine the efforts that you are undertaking.

Mr. VLADECK. I am happy to respond. Let me say first that we have informed the GAO through our testimony presented during other committees in the past that we believe the GAO's contention indicating the costs have grown from $150 million to $1 billion is simply wrong. The GAO is comparing cost estimates that estimated two dissimilar things, and there have been increases in the estimated costs over the life of the project. The design of the project has evolved considerably.

The fact is, Madam Chairwoman, without getting into a long technical argument, we are now spending approximately $1.5 billion a year operating the current Medicare claims processing system. For instance, over a 10-year period, much of the cost of installing a new system is implementing it at the sites at which claims are processed. In determining the estimated costs, the incremental or differential cost of operating a claims processing system with the old system and the new system must be considered. This is how we obtained our billion dollar estimate. The $150 million estimate, that was made earlier in this decade, was made on an entirely different basis. Therefore, we simply disagree with GAO regarding their cost estimate comparison.

Senator COLLINS. What is your estimate, then?

Mr. VLADECK. Well, we are estimating that over the life cycle of the project, the total development and implementation costs of the program will be in the range of $1 billion.

Senator COLLINS. It will be $1 billion?

Mr. VLADECK. Yes, that is correct.

Senator COLLINS. It is my understanding that is what GAO estimated.

Mr. VLADECK. Well, again, we are not disagreeing with the estimate. We are disagreeing with GAO's use of the earlier figure as a comparison figure.

Senator COLLINS. As the comparison.

Mr. VLADECK. In keeping with recent Congressional legislation and the directive of the Office of Management and Budget, we have adopted, through the strategy for the development of the Medicare Transaction System, a so-called investment management strategy. The principal objective of this strategy is to minimize the risk to taxpayers of excessive costs in the development of a system or in unsuccessful development activities. We are proceeding on this basis, and that is frankly one of the reasons why the costs have increased. What we have done is to slow down the development of the system and have broken it into more incremental pieces. We have adopted a strategy that is much longer terms and it is going to take much more separate steps. The risk of wasting money as part of that strategy will be significantly reduced, but it will take us much longer to put the new system fully into place. Full implementation will be later in the future, at which point we will begin to generate the savings that a single, unified database will achieve. However, we are currently proceeding in an especially cautious and stepwise fashion with the system development.

Senator COLLINS. One final question before I turn to Senator Glenn for his questions. Some of our witnesses this morning essen-

tially said that HCFA now has the resources and the tools that it needs as a result of the Kassebaum-Kennedy Act and other legislation that is going to be enacted now to get a handle on this problem. Do you agree with that, or are there further legislative steps or resources that you believe you need in order to tackle this problem effectively?

Mr. VLADECK. Well, again, we do believe that there are a number of provisions in the HIPAA when implemented which will be of enormous benefit. As I suggested in my opening statement, we have had a number of proposals as part of the budget reconciliation process that are quite important to us in this regard.

If we can all continue to be optimistic about the conferencing of the budget reconciliation legislation and its emergence in the very near future, we would not be currently suggesting significant additional legislative authorities. We believe that we will then have most of the tools in place. It will be quite appropriate for HCFA to return to Congress in a year and a half to report on HCFA's progress in implementing new anti-fraud provisions contained in the HIPAA and budget reconciliation legislation.

Senator COLLINS. Thank you. Senator Glenn.

Senator GLENN. Thank you, Madam Chairwoman.

I know it is getting late, and we appreciate your sticking with us for all this time, but we have had problems this morning, obviously.

According to *The Wall Street Journal,* Medicare home health care outlays have tripled over the past 5 years and are now at about $22 billion and apparently are still going up. Now, that was by intent to some degree, because we thought that might be saving hospital costs and other things. Are there any studies that show what offset there is for this? As we have moved into this and gone to more home health care, have we seen the savings that were supposed to occur from some of this?

Mr. VLADECK. Probably the most useful recent analysis of this has been the work done by the Prospective Payment Assessment Commission. This Commission advises the Congress on Medicare Part A activities. In ProPAC's June report of last year, the Commission considered this issue in great detail and suggested that not only has there not been a substitution effect by the growth in home health, but that in fact, the events over the last half dozen years have led to Medicare increasingly paying twice for the same service rather than paying somewhat less for the same services.

Much of the legislation that we have been working on having to do with payment reform in Medicare, involving not only home health, but payment to hospitals, has been very much in response to ProPAC's studies.

Senator GLENN. If I understand you correctly, then, the offsets that we thought might occur are just not evident yet.

Mr. VLADECK. No; if anything, the opposite—instead of paying less, we are paying twice.

Senator GLENN. The March report—this is a year-old GAO report now—said that controls over the Medicare home health benefit remain essentially nonexistent. Have you been able to put anything into place in the last year now to start monitoring that?

Mr. VLADECK. Well, we have done a lot of monitoring. I think one of the things—and to pick a small quarrel with the GAO testimony—that has been ignored in the discussion of this issue in the testimony is that in the early 1980's, after the 1981 GAO report, HCFA put into place a number of very aggressive controls on home health care claims. As a result of HCFA's controls, a coalition of consumer and provider groups brought a lawsuit against HCFA which was adjudicated in the District Court in the District of Columbia in 1988. This lawsuit resulted in one of the most blistering decisions which I have ever read attacking an administrative agency by the judge. Subsequent to which my predecessors entered into a consent decree to settle the litigation, and it largely gave away HCFA's ability to effectively review individual home health claims.

Included in the new legislation are provisions which we hope will soon be enacted. These provisions provide for a number of changes in the underlying statute. For the first time, proposed changes will supersede the consent decree and permit HCFA to have a much better handle on many home health claims which we have been unable to effectively review over the last 7 or 8 years.

Senator GLENN. You talked about additional legislation and the competitive bidding a little bit. How about this idea of the billing codes? I was not aware of that until this morning—that was a new wrinkle for me—where you have certain equipment provided for under a billing code, and it can be either good stuff or poor stuff, and there is a big difference according to the charts we had displayed here earlier this morning, which I think you saw.

Are you moving in that area—it is apparently a real problem, because we are paying three times in some areas what we should be paying, compared to what the VA is paying. Is that a major problem, and are we breaking those billing codes down in some way, or how are we taking care of that problem?

Mr. VLADECK. I believe that the current statutory requirements for how we set prices for durable medical equipment are causing HCFA to overpay very, very significantly. There is no question, and we have——

Senator GLENN. And that is required by law.

Mr. VLADECK. That is required by law and it is specified in significant detail in the statute. We do believe that competitive bidding will often be the best approach. Expansion of our "inherent reasonableness authority," which is also in the Senate legislation, would be helpful for services for which competitive bidding is in appropriate, involving circumstances where there is only one supplier in a rural community or only one supplier of an esoteric item.

With respect to the narrower issue of billing codes, we currently require a particular item code for each durable medical equipment bill. The suggestion, as I understand it today, was that we use the uniform product identifier number code rather than the coding system which we have been using. I believe that this idea is a very intriguing and positive suggestion.

In accordance with the administrative simplification requirements of HIPAA, we are obligated to lead a national public-private participative process to get agreement on standardization of all this kind of coding and other information. Standardization is very much on the agenda for that process.

Senator GLENN. Professor Bucy brought up the issue of underproviding. Is that a problem that you are monitoring, and how do you monitor that?

Mr. VLADECK. It is potentially a very serious problem. We have, effective this past January 1st, required all HMOs participating in the Medicare program to participate in the data and reporting system that is commonly referred to as HEDIS, the Health Care Employers Information Set. The National Committee on Quality Assurance has used HEDIS as the first effort to measure the actual provision of service by HMOs. All of our HMOs will be reporting to us on the frequency of mammographies and other kinds of procedures. There are 26 different items in the HEDIS dataset, and we will have independent audits of the accuracy of that data as a first step, but by no means a complete and systematic effort to begin resolving this issue of under-provision.

We will also be administering a public opinion survey to Medicare HMO enrollees this fall that will have a sufficiently large sample size to ensure a statistically representative sample of each plan. This survey will permit us to report on patient satisfaction scores involving issues like access, availability of physicians, and availability of procedures. These are the first two steps in a multi-year effort and a multi-year plan to address these particular concerns.

Senator GLENN. OK. Are you doing any contracting with outside firms for utilization review, and what has your experience been in that area?

Mr. VLADECK. We require our providers to, in many instances, contract with outside firms for utilization review. In accordance with the statute, we contract in every State with a peer review organization to do the basic utilization review for a range of identified Medicare services. These relationships are statutory.

We have invested a lot of time and effort into the efforts of the PROs over the last several years, and we are learning how to do it considerably better. We are beginning to find measurable improvements in some areas involving patterns of care.

We believe that under the new HIPAA authority, we will be contracting with a much broader range of organizations to perform specified kinds of program integrity reviews in the Medicare program. We are examining a number of potential participants in that process and involvement.

Senator GLENN. We are talking mainly about fraud and abuse and all those things in the Medicare programs, but just to touch on one of the other problems for a moment—I do not know whether it is still a problem or not—but at least some time back, you were having problems getting a lot of doctors to sign up under Medicare. They did not like the paperwork; it was too much hassle, and they were just running in their own direction. So in some places, a lot of doctors were not accepting Medicare patients, or they preferred not to and would make a decided effort not to have Medicare patients. Is that still a problem?

Mr. VLADECK. It is in some isolated pockets of the country, Senator Glenn. On average nationally, the proportion of all physicians participating in the Medicare program in 1995 is the highest that it has ever been. We anticipate having the 1996 data available soon. Well more than 90 percent of all physicians licensed to prac-

tice in the United States are now participating in the Medicare program.

The other Congressional advisory committee, the Physician Payment Review Commission, has identified 15 communities around the country in which they are concerned about problems of access to practitioners for Medicare beneficiaries. We are conducting special reviews of these communities. On average, the proportion of physicians in practice who do not see Medicare patients is at an all-time low.

Senator GLENN. Just one other thing. You talked about the expense of the MTS system and how much it is going to cost. I am concerned that we not just go from fraud on paper to fraud by computer once we get there. I hope you are building some protections into that system, and I do not know whether similarities are enough between our experience with IRS and what you are designing that would be something you should have some meetings on over there.

We have been at the tax system modernization here, and we are some $3.5 billion into it. I do not know how many hearings I have personally conducted in this room on IRS and tax system modernization, but it is quite a batch, as well as GAO studies and so on. As you move into this area, I would just implore you to talk to them at least about some of the problems they have had in trying to implement a great big system like this. You have 822 million claims a year, and that is fairly small compared to what IRS has, I think, in the number of things they have to process. But I hope you are talking to them over there so you can perhaps avoid some of the pitfalls they encountered, because we had a sad experience with that.

The question is: Are you consciously building into this protections against fraud and abuse in some way—and I do not know how you do that; I am not enough of a computer whiz to know how you do it—but are your people considering that as they design this system and move into it? If not, they should be.

Mr. VLADECK. I am glad you ask that, Senator, because it permits me to mention a computer project of which we are particularly proud. We have contracted with Los Alamos National Laboratories to apply some of the very super-computer pattern recognition technology which were first used in national defense applications as a technique for detection of patterns of fraud and abuse in Medicare and Medicaid billing.

Los Alamos National Laboratories has actually already had a great deal of success with the commercialization of this technology for the protection of credit card fraud. For instance, anyone who has received a call from his credit card company lately, asking if they went to Hawaii last week or whatever, because the company found some unusual charges, may be familiar with this new technology.

We are not waiting for the new computer system to put in place this kind of technology. We are pilot-testing it in two States already. The new system will plug into this kind of very highly sophisticated pattern detection fraud and abuse technology as well as some of the more old-fashioned kinds of editing processes.

Senator GLENN. And while you are building it in, too, you want some of the protections against hackers getting in and fouling up the system, like the one that NSA has done a lot of work on, how to prevent things like that with people hacking into Pentagon codes and command circuits.

There was a Russian—if I could digress a little bit for 30 seconds—a Russian hacker a couple of years ago who got into one of the big investment house computers in New York and transferred a million or two out to an account of his in Los Angeles and some more to a bank account in Switzerland. And it is a new way of making warfare if you want to consider it that, because if you had 500 or 1,000 trained hackers to go into transferring Merrill Lynch accounts to the Fed and your bank account to the Fed and the Feds to you—and you would probably come out ahead on that detail—but you transfer these things around, and you foul up the economic system of the whole country. It is to that level of importance now.

So the point is where you are setting up a brand new system like this, and where there has been fraud and abuse, you may want to contact the NSA people and have them give you some advice on how you can set this up to prevent people from getting into your system. There has been fraud and abuse in here, and there is going to be more as you go to computers if you do not do it right.

Thank you much. That is all.

Senator COLLINS. Thank you.

Thank you very much, Mr. Vladeck. We look forward to working with you. This is going to be an ongoing investigation.

I want to thank Senator Glenn for his participation in this hearing.

We will have some additional questions for the record that we would ask your cooperation in answering.

Mr. VLADECK. I would be delighted.

Senator COLLINS. And all the charts of our witnesses will be made a part of the record, which will be left open for 10 days.

I want to thank everyone for coming today. I particularly want to thank my staff for an excellent job in putting together this hearing, led by Tim Shea, our Chief Counsel. The PSI staff, including Ian Simmons, Don Mullinax, John Frazzini, Mary Robertson and Lindsey Ledwin, worked very hard on this hearing. Medicare fraud is going to be an ongoing effort of the Subcommittee. And I want to thank Senator Glenn's staff as well for their cooperation.

This hearing is now adjourned.

[Whereupon, at 12:40 p.m., the Subcommittee was adjourned.]

APPENDIX

TESTIMONY OF
SENATOR CHARLES E. GRASSLEY

HEARING ENTITLED
"MEDICARE AT RISK"
Emerging Fraud in Medicare Programs

JUNE 26, 1997

Good morning to my distinguished colleagues, and of course I would like to say a special thank you to you Senator Collins, for inviting me to testify at this important hearing, a hearing that will present an overview of fraud, waste and abuse in the health care system.

My statement today will be short. In addition, I regret to say that immediately after my testimony today, I will need to leave for another engagement. So, I would be happy to respond to any questions that the Committee may have in writing.

Fraud, waste and abuse are enemies of the health care system. It is a disease that is taking health care services from our children, our spouses and our elderly parents. It costs us unnecessary millions every day--money that could and should be put to better use.

As Chair of the Special Committee on Aging, it is a pleasure to bring to your attention the findings of a General Accounting Office (GAO) report released to me just a few days ago--a report regarding the prices that we taxpayers pay for medical equipment and supplies, as well as the fact that Medicare often overpays large-volume suppliers. (Exhibit 1)

In 1996, the Medicare system paid out about $4.3 billion dollars for medical equipment and supplies used in 1996--$4.3 billion dollars. I brought a few examples of the medical equipment and supplies that Medicare pays for- it pays for walkers, catheters and glucose strips. What the GAO had to say in its most recent report is alarming and troubling. Specifically the GAO said that the Health Care Financing Administration, known as HCFA---does not know specifically what products it is paying for when it pays for medical equipment and supplies. Could you ever imagine paying someone for supplies that they are delivering to your patients, clients or agents and not knowing exactly what you are paying for--- you would not be in business very long. Indeed this situation reminds me of the unmatched disbursements at the Department of Defense. Specifically, DOD does not want to do accounting work as a transaction occurs--like other businesses do.

Of course, the very next question one would ask after learning that HCFA doesn't know exactly what medical equipment and supplies it pays for is---WHY NOT? The reason is that HCFA does not require suppliers to identify specific products on their Medicare claims.

Instead, suppliers use HCFA billing codes that usually cover a broad range of products of different types, qualities and market prices. Because Medicare pays suppliers the same amount for all the products covered by a billing code, the supplier has a financial incentive to provide the cheapest products covered by the billing code.

Perhaps an example will be helpful and that is why I have these different types of catheters. Let's say that I am a supplier of catheters. I have catheters that cost me -- as a supplier -- $1.00 and I have some that cost $17.00. (Exhibit 2) And what does HCFA pay -- about $10.00 for all the catheters under the billing code. So, if you are a supplier, you would be crazy to supply the expensive catheters, when you could supply the cheaper ones. What a great deal if you're a supplier--what a bad deal if you're one of the millions of taxpayers that pays into the Medicare system.

This example demonstrates vividly that the 4.3 billion dollars that we are spending annually for medical supplies and equipment is higher than it need be. It also tells me--like it or not--that we have a payment system here that is "just plain broke."

Now let me shift for a moment and discuss what can we do with something that's "just plain broke." As a father, grandparent and legislator, I have a commitment and duty toward improving the situation. In its report, the GAO said that the billing code system that HCFA uses provides insufficient information for properly identifying and paying for products billed to Medicare. This need not be the case.

The Department of Defense and some health care purchasing groups are beginning to require their suppliers to use product-specific codes--called universal product numbers--just like those used in your grocery store. These universal product numbers identify the individual medical product. In this manner--you get what you pay for--plain and simple--not-- you pay for what you don't get.

I say that HCFA should be required to do the same. In that vein I will introduce legislation and hope that you Senator Collins and the other Members of this prestigious Subcommittee will join me in insuring that HCFA immediately begins an intensive effort to initiate universal billing codes for medical equipment and supplies that are billed to the Medicare program. In this way we will dramatically improve the system. Then we can re-direct those savings to other areas in need of attention in Medicare.

I would be remiss if I did not take this opportunity to encourage Americans, across this great nation to use "qui tam." Some may ask--what is "qui tam." Well, "qui tam" is a civil legal action where a citizen can file a suit on behalf of both him/herself and the government for violation of a statute that provides a specific penalty for wrongdoing. If the case works out, the individual may keep a part of any resulting penaltities.

Thank you for the opportunity to testify Senator.

Statement of Senator Tom Harkin (D-Iowa)
Ranking Member, Appropriations Subcommittee on Health and Human Services

Before The
Permanent Subcommittee on Investigations
Senate Committee on Government Affairs

June 25, 1997

Madame Chair. I want to commend you for dedicating one of your first hearings as chair of this important subcommittee to the subject of fraud, waste and abuse in Medicare. It is extremely important that we work on a bipartisan basis to attack this huge problem.

This is a problem that I have been working on for years as chair and now ranking member of the Senate appropriations subcommittee that funds and has oversight over the administration of the Medicare program. Since 1989 we have held hearing after hearing and released report after report documenting unnecessary losses to the Medicare program.

The losses are truly staggering. The General Accounting Office has testified before our subcommittee that up to 10 percent of Medicare payments could be lost to fraud, waste and abuse. That adds up to about $18 billion last year. The HHS Inspector General just concluded a comprehensive audit of a statistically valid sample of Medicare claims that were paid last year. It is the most comprehensive review of claims ever made. The audit projects that up to $23 billion of those payments, or about 14 percent should not have been paid. So the problem may be even worse than we had previously thought.

There are many components to this problem. If you can dream up a scam or rip-off, it's probably already been tried. We've uncovered losses due to out and out fraud. Providers billing for services that weren't actually administered. Providers paying and receiving kickbacks. Double billing. We now even have evidence that organized crime has entered the Medicare fraud business. Clearly, there is a lot of criminal activity going on out there that is costing American taxpayers billions of dollars each year.

However, we've found, with the help of the GAO and the Inspector General that even greater losses are due to waste and abuse. Those losses are often directly due to or encouraged by wasteful Medicare payment policies and practices. And, at long last, it appears that the budget bill before the Senate will address some of the most glaring problems. It would make changes that I have been pushing since the beginning of this decade.

The main changes to which I refer are competitive bidding and a streamlining of Medicare's authority to pare back grossly excessive payment rates. These two steps, if appropriately implemented, will cut waste and save taxpayers and Medicare beneficiaries billions of dollars.

The need for these reforms couldn't be clearer. Let me give you an idea of what I'm talking about. Last year I released a report prepared by my staff on waste in Medicare payments for medical supplies. Remember the $500 toilet seats from the Pentagon? Well, the good news is that the Pentagon isn't buying them anymore. The bad news is that Medicare is.

Our analysis of Medicare payments for a sample of medical supplies and equipment -- from saline solution to hospital beds -- reveals that Medicare is paying up to 6 times more for these items than other government and private sector purchasers. The losses to the program, and to seniors and other taxpayers, are staggering.

For just the 18 items we reviewed, Medicare could save over **50 percent** or up to **$236 million** this year and **over $1.6 billion** over the next 7 years if it paid the same rates paid by the Veterans Administration. If Medicare were to simply pay a wholesale rate offered to others around the country, it could achieve nearly identical savings -- up to $218 million this year and $1.5 billion over the next seven years. Medicare could even save $371 million over the next seven years if it just paid the suggested retail rates for this sample of supplies and equipment.

We found that Medicare pays up to $182.80 to rent an air pressure mattress, more than 6 times the wholesale price of $29.95 and nearly 3 times the retail price of $53.88. Medicare is paying $99.35 for a simple commode chair that the V.A. is able to buy for $24.12 and you can get wholesale for $39.99. And Medicare pays $7.90 for a bottle of sterile saline solution that V.A. is able to purchase for $2.38.

The reason for this disparity is that the V.A. engages in good old free market competitive bidding. While Medicare pays bloated prices based on historical charges, the V.A., which has much less purchasing power than Medicare, puts out bids that provide for both quality and cost control. The V.A. is able to save taxpayers money because they use competitive bidding to ensure get the best rate possible. Medicare is currently prohibited from using this cost saving measure. But the bill before us give them that much needed authority. Again, it'll save us billions over the coming years if appropriately implemented.

Another important reform is a streamlining of Medicare's authority to reduce grossly excessive payments for items it purchases. It's called the "inherent reasonableness authority." Under current law, the authority is torturous to complete. As a result, it has been used only once.

Three years ago, we found that Medicare was paying up to $211 for this home diabetes monitor. At the time, I sent a staffer out to the local K-Mart and got it for $49.99.
After several hearings, we got Medicare to begin the process of using their authority to reduce this gross overpayment. It took them two full years to go through all the hurdles set up in law. They finally reduced the payment to around $50 and that alone is saving taxpayers $25 million over 5 years. But it took 2 years! That delay cost taxpayers $10 million.

Medicare ought to be able to do a quick survey of the nation to determine acquisition costs and a reasonable add on and make the change immediately. No private business could stay afloat with that kind of wait before they could adjust to changes in the marketplace.

The Senate balanced budget bill includes a streamlining of this process that I have suggested for years. It would allow Medicare to respond quickly when it finds that it is paying prices that are out of line with what everyone else pays.

Madame Chair, I would urge that this subcommittee join my subcommittee and the Finance Committee in closely monitoring the implementation of these very important new provisions.

I also want to briefly talk about a study I requested by GAO that I would like to formally present to the Subcommittee. The report, "Need to Hold Home Health Agencies More Accountable for Inappropriate Billings," presents some startling new information. The GAO found that of the sample of home health claims they reviewed, fully 43 percent of the claims that Medicare paid should have been denied. They found that one reason for this shocking result is that Medicare only reviews about 3 percent of all home health claims. The rest they pay without looking at them. They don't have adequate funding to conduct those reviews.

GAO has developed an innovative solution to this funding shortfall that I hope we can work out to include in this year's appropriations bill. They recommend that Medicare test a system whereby agencies that have been identified as having high levels inappropriate billings be subject to comprehensive audits at their expense. I'd like to work with the members of this committee to get your ideas about how we can make this basic idea work.

Again, madame chair, thank you very much for the opportunity to address the subcommittee. Thank you.

Medicare Fraud & Abuse

Testimony of Michael F. Mangano
Principal Deputy Inspector General
Department of Health and Human Services

Hearing before the
Senate Committee on Governmental Affairs

Permanent Subcommittee on Investigations

June 25, 1997

Office of Inspector General
Department of Health and Human Services
June Gibbs Brown, Inspector General

Michael F. Mangano
Principal Deputy Inspector General
Department of Health and Human Services

Good morning, Mr. Chairman. I am Michael F. Mangano, Principal Deputy Inspector General of the Department of Health and Human Services, and I am here to report to you on our efforts to combat fraud, waste, and abuse in the Medicare program.

Medicare is one of our nation's most important social programs. It provides health care coverage for more than 38 million elderly or disabled Americans. Unfortunately, it also presents many opportunities for unscrupulous individuals to steal from U.S. taxpayers. Because of the huge sums of money being spent in support of Medicare--$191 billion estimated for FY 1997--there will always be individuals or companies that attempt to game the program purely for their own profit. We in the Office of the Inspector General have literally been waging a continuous war against this fraud and abuse since 1977.

Since last October, the Office of Inspector General and the Department of Justice have been involved in the resolution of over 700 criminal and civil cases that have led to settlements of over $1 billion for the Medicare Trust Fund, and we have excluded over 980 fraudulent and abusive providers from program participation. Once a program exclusion is imposed, Federal program payments may not be made to any individual, business or facility for items or services furnished, ordered, or prescribed by the excluded individual or entity. Exclusions imposed by the OIG apply not only for HHS and State health care programs, but also for all other Executive Branch procurement and non-procurement programs and activities. This means, for example, that a health care provider excluded from Medicare, Medicaid, and other State health care programs will be unable to continue participating in the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) program administered by the Department of Defense or in the Federal Employee Health Benefits Program (FEHBP) administered by the Office of Personnel Management.

Convicting abusive providers, keeping them out of the program, levying fines, recovering overpayments, negotiating settlements--all these actions are necessary to reduce Medicare fraud and abuse. But they will never be more than the second best way to do this. The best way is to prevent fraud, waste, and abuse from ever occurring in the first place. This requires identification and correction of vulnerability built into the programs themselves or into the management systems used to administer and monitor them. We find that most health care providers are honest. Only a few set out with intent to defraud the program. However, systemic weaknesses create gray areas that make Medicare vulnerable to abusive and improper billings, increasing the risk of improper payments.

Vulnerability to Abusive and Improper Billings

One source of vulnerability is the design of the benefit categories and reimbursement criteria themselves. Our audits, investigations, and evaluations often reveal patterns of unintended incentives, inherently ineffective controls, poorly defined eligibility criteria, excessive reimbursement rates, unmeasurable outcomes, baselines premised on inaccurate assumptions, and

believe the differences are due mostly to the discretion afforded home health agencies to influence the amount of care given to their clients.

We believe that the Health Care Financing Administration can strengthen controls of the home health benefit through several methods like restructuring the HHA reimbursement methodology by establishing a prospective payment system; placing a limit on the number of visits allowed per beneficiary; establishing a system of pre-authorizations; and/or establishing a copayment. In addition, programmatic operational actions can be taken such as emphasizing key policy points in the Medicare HHA manual and improving guidance; revising Medicare regulations to require the physician to examine the patient before ordering home health services; requiring intermediaries to provide beneficiaries with explanations of Medicare benefits for home health services so they can see the visits being charged to Medicare; and instructing intermediaries to augment focused medical reviews with physician and beneficiary interviews. HCFA should ensure more effective reviews of home health agencies, use of case management, and adequate funding for fiscal intermediaries to detect inappropriate claims.

I would like to note that this subcommittee issued a report back in 1981 on home health that recommended, as we are recommending today, that HHAs should be reimbursed under a prospective payment system. The subcommittee believed that a prospective payment system would force HHAs to be more cost-efficient in order to meet the target rate. In the absence of a prospective payment system, the subcommittee recommended that HCFA take a variety of actions including competitive bidding of subcontracts, competitive selection of intermediaries, and expediting regulations to require bonding of HHAs in their first 5 years of operations or under certain other conditions. The subcommittee encouraged increased intermediary audits of HHAs, better notification of HHAs regarding policy changes, and asked HCFA to pursue the use of termination and exclusions.

Medical Equipment and Supplies. Over the years, we have devoted significant resources to issues involving medical equipment and supplies. The problems have included claims for equipment that was never delivered, upcoding, unbundling, medically unnecessary equipment, and excessive payment rates. Our work has disclosed losses totaling several hundred million dollars for incontinence supplies, wound care, lymphedema pumps, and orthotic body jackets. We previously found abuses relating to seat lift chairs and power operated vehicles.

The widespread problems in this area have been due in part to high profit margins, ease of entry into the system, and weaknesses in payment safeguard functions. We believe that legislative and regulatory actions are needed to tighten up entry of suppliers into the Medicare program, and to give the Health Care Financing Administration greater authority to set prices for equipment and supplies. However, such authorities are needed throughout the Medicare program, not just in the area of supplies and equipment.

A specific area of concern is the home oxygen benefit. For beneficiaries who are deficient in the amount of oxygen in their blood, Medicare covers both oxygen and oxygen supplies and equipment, including the system for furnishing it, the vessels that store it, and the tubing and administration sets. Allowances more than doubled from 1992 to 1995, rising from $835 million to more than $1.6 billion. The root of the problem is not so much with billing abuses as with the fact that Medicare cannot get competitive prices. Even though it is a high-volume payer,

other such design weaknesses. When we spot these kinds of problems, we issue reports recommending regulatory or legislative reforms. Our office has testified before the Congress on many of these problems. Based on a review of all of our work in recent years, I would like to highlight here what we believe are the areas of highest risk for abusive and improper billings to the Medicare program.

Home Health. Between 1990 and 1996, expenditures for home health benefits had grown five-fold from $3.5 to $16.9 billion, and the number of beneficiaries increased from 2 to 3.7 million. Utilization also doubled, from an average of 36 to 76 visits per beneficiary. Some of the growth is appropriate and expected due to changes made to the benefit, demographic trends, technological advances, and a trend toward providing more care in the community instead of in institutions.

Unfortunately, fraud and abuse may also be a factor. Recently completed audits of eight home health agencies (HHAs) in Florida, Pennsylvania, and California have revealed that from 19 to 64 percent of the home health visits paid for by Medicare did not meet Medicare guidelines. We found visits that were not considered reasonable or necessary, patients who were not homebound, inadequate physician authorization, and services claimed but not provided. Preliminary results from a study in four of the largest States confirm these conditions are wide-spread. Following are a couple of examples of fraud and abuse in the home health industry:

> False Cost Reports. First American Health Care of Georgia, Inc. was the largest privately held home health care provider in the country. When our investigation began, the company was known as ABC Home Health. Jack and Margie Mills were the majority shareholders and chief officers of the company and its subsidiaries. After extensive investigation and audits by the Office of Inspector General, the Mills and the First American parent company were convicted of several Medicare-related criminal offenses and were excluded from participating in the Medicare and Medicaid programs. The Mills' received significant prison time, and the related settlement provides for a return of $255 million to the United States. Offenses included improperly shifting unallowable costs onto Medicare cost reports such as lobbying and advertising expenses and promotional items such as $84,000 in gourmet popcorn. The company and its owners claimed items and services that benefitted the owners personally as reasonable and necessary "general and administrative" expenses related to the care of Medicare patients (e.g., golf course memberships, greens fees, a family vacation, and an expensive car for a son in college).
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> Services Not Rendered. On a smaller scale, the co-owner of a Washington, D.C. HHA was sentenced to 27 months in prison and ordered to pay full restitution of $100,000 defrauded from the Medicare and Medicaid programs. The HHA billed for 1,450 skilled nursing visits for which there are neither time slips nor nurses' notes documenting the visits were made. It also billed for home nurse visits when patients were actually hospitalized. Another co-owner was also convicted but has been in escape status since leaving his detention center assignment.

We have also found extreme and seemingly unjustifiable variation in payments to home health agencies. In 1994, lower cost home health agencies (those which provided less than the national average of visits per episode) averaged 33 visits per episode, whereas the higher cost agencies (those with visits per episode above the national average) average 102. Based on our studies, we

Medicare is not able to negotiate volume prices as high-volume purchasers normally do. Medicare paid more than twice as much for oxygen equipment and supplies as the Department of Veterans Affairs according to our 1991 study. The difference remains greater than 40 percent in 1996. The Health Care Financing Administration estimated the savings could be at least $200 million per year from a 40 percent reduction on reimbursement for oxygen concentrators. In May 1997, the General Accounting Office (GAO) issued a report comparing Medicare and VA payments for home oxygen supplies and services and concluded that if Medicare had paid for oxygen and related supplies and services at the adjusted VA rates, the Medicare program would have saved as much as $500 million in FY 1996. The VA uses competitive bidding to lower its costs. Medicare does not have that option. Legislative options include allowing for competitive bidding or setting special payment limits.

Other program weaknesses create conditions in which Medicare pays more than it should, pays inappropriately, or pays improperly because of false billings. I would like to describe some examples of fraud in the medical equipment and supplies arena:

Incontinence Supplies. One of the highest-reimbursed Medicare suppliers of incontinence care products agreed to plead guilty to conspiracy to defraud Medicare of more than $70 million. He distributed adult diapers to nursing homes (which are not covered by Medicare) but billed Medicare for female urinary collection pouches. He agreed to forfeit $32 million in seized bank accounts, paid $2.5 million in restitution, and was sentenced to 10 years imprisonment. Another incontinence care supplier defrauded Medicare of $25 million, forfeited $12 million, and was sentenced to 57 months incarceration followed by 3 years supervised release.

Durable Medical Equipment. At least 19 individuals have been convicted in connection with over $20 million in false billings of durable medical equipment and supplies by a major supplier and related companies. The individuals were owners, physicians, sales people, and an accountant. The physicians were charged with signing medical necessity forms for equipment which was never received or needed, without seeing the patients. The sales people were charged with recruiting Medicare beneficiaries by giving them nonreimbursable items such as microwaves and air conditioners, while the company billed Medicare for reimbursable items such as hospital beds and wheelchairs. Several sales people were Russian or Hispanic and were targeting Russian and Spanish-speaking beneficiaries. One physician who was sentenced in absentia fled to the Dominican Republic and cannot be extradited at this time.

Lymphedema Pumps. These pumps are pneumatic compression devices that are used to treat swelling of tissues resulting from accumulation of fluid from lymphatic blockages. The pumps range in sophistication and can cost from $600 to $6000. One supplier was sentenced to 1 year in prison and 3 years supervised release and was ordered to pay $294,860 in restitution, fines, and penalties. He billed Medicare for lymphedema pumps at $4,500 each, but he delivered pumps that would have been reimbursed at $600 and pocketed the difference.

Nursing Homes and Related Services. The Medicare and Medicaid programs together paid $46 billion for nursing care of all kinds in 1995. This included $42 billion in payments to nursing

homes ($9 billion under Medicare Part A and $33 billion under Medicaid), and $4 billion under Medicare Part B in payments to various providers of medical supplies and services for Medicare beneficiaries residing in nursing homes.

We have found a variety of problems including inappropriate billings for mental health services for patients in nursing homes. At least $17 million, or 24 percent of all such billings, were in error in 1993. This included payments for socialization events billed as group therapy and payments for psychotherapy sessions for individuals not needing them and with diminished capacity to gain any benefit from them. Following are two examples of inappropriate billings for mental health services to nursing home residents:

> Psychology Services. A company which employed psychologists to provide services to nursing home residents entered a civil settlement agreeing to pay $700,000 to settle allegations that it submitted false Medicare claims. The company billed for 45 to 50 minutes of psychotherapy to nursing home residents when only 20- to 30-minute sessions were held. Some of the psychologists billed for more than 14 hours of therapy a day -- one billed for the equivalent of more than 24 hours a day.
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> Psychiatric Services. In another example, a psychiatrist signed an agreement to pay the Government $300,000 to settle. He provided psychiatric care to Medicare beneficiaries in nursing homes in California, Rhode Island, Florida, Texas, New York, Washington and Oregon. His scheme involved duplicate billing through two separate entities, both of which he owned. During the investigation, his various companies were found to have 24 different mailing addresses, 23 different telephone numbers, and at least 12 different provider numbers.

We have become increasingly concerned about cost shifting from Medicare Part A to Medicare Part B in the nursing home setting. Nursing home residents are accessible and can be vulnerable, providing a unique opportunity for fraud, waste, and abuse. Unless protected by concerned family or friends, the attending physician, or enlightened policies and practices of the nursing home, nursing home residents may be subjected to health care practices in which decisions on care are governed as much by financial incentives as medical necessity.

We support the idea of a prospective payment system for Medicare Part A nursing facilities and would also advocate that this or a similar approach be more widely used by States under their Medicaid programs. We urge that as many services as possible be included in the prospective payment rate, such as most payments for enteral nutrition, incontinence supplies, and wound care. Services which are not included in the prospective payment rate should be consolidated into a single bill to be submitted by the nursing home under Medicare Part B, if appropriate.

It is just as important to ensure quality of care as it is to control costs. Prospective payment systems will bring their own incentives, some of which may provide a risk to quality of care through premature discharge or refusal to accept patients with complicated conditions. Therefore, it may be necessary to include higher payments for outlier cases and anti-dumping provisions similar to those that apply to hospitals.

Laboratory Services. We are nearing completion of a multi-year investigative initiative called LabScam. This is targeted at abusive marketing and billing practices, particularly "unbundling" which is the practice of running specimens through a single piece of automated multi-channel laboratory equipment and then billing separately for each component test. So far our investigation has generated receivables of over $800 million. Initially we focused our efforts on large, independent laboratories. We are now directing our attention to hospital outpatient labs. Here are two examples:

> Independent Laboratory Case. SmithKline Beecham Clinical Laboratories was named in a number of suits related to marketing and billing abuses common to all the laboratories, including unbundling. SmithKline entered into a settlement agreement and a corporate integrity agreement with the Federal Government. The company agreed to pay $325 million and implement a stringent compliance plan under the supervision of the Office of Inspector General to settle its civil liability for false billings.
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> Hospital Outpatient Laboratories. As a result of a review of hospital outpatient laboratory billings in one State, we are expecting about 25 settlements amounting to about $10 million. We found that these hospitals were widely practicing unbundling of tests and submitted erroneous or excessive claims for urinalysis, organ panel, hematology and automated blood chemistry tests. This review is being extended nationally.

Fraud is not the only reason laboratory services are rising so rapidly. Incentives for increased utilization can be found in the practice of defensive medicine. Much of this is legitimately needed, but some of the increased utilization may be unnecessary. The frequency of testing for the Medicare population increased 96 percent from 1986 to 1993, while the population increased by only 14 percent. For all these reasons, laboratory services is one area we need to keep a close watch on.

Hospitals. Our short list of potential program vulnerabilities includes the largest or fastest growing components of the Medicare program. This certainly includes hospitals, the largest single destination of Medicare payments. According to the 1997 Annual Report of the Board of Trustees of the Federal Hospital Insurance Trust Fund, payments for the costs of fee-for-service inpatient hospital care represented 67 percent of Part A benefits. Based on Part A benefit payments of $128.6 billion, fee-for-service inpatient care amounted to $86.2 billion in calendar year 1996. We find a high risk for upcoding of discharge billings, gaming of the prospective payment window, and using accounting techniques to exaggerate "losses" upon the sale of facilities and then billing Medicare for millions of dollars to cover its share of these spurious losses.

> Upcoding of discharge billings. Most hospitals are paid based on a diagnosis-related group (DRG) code for each discharge under the prospective payment system. Medicare does not currently have a process in place to validate the codes and assure proper payment is made. We are studying the use of commercial software currently used to detect billing irregularities and will determine the extent to which hospitals are upcoding hospital discharges for Medicare payment; that is, charging for a higher level of service than was actually delivered. We are finding upcoding with regard to conditions such as respiratory illnesses. The incentives and opportunities for upcoding are enormous, given more than $86 billion in annual reimbursements and the largely unmonitored billing environment. In

our audit of HCFA's financial statements, we looked at a sample of hospital claims and are very concerned about an apparent lack of support for the level of DRG being claimed in some cases. More specific work will ensue from that review.

Prospective payment window. We are finding a substantial number of overpayments made to hospitals as a result of claims submitted for nonphysician outpatient services that were already included in the hospital's inpatient payment under the prospective payment system. Hospitals that submit claims for the outpatient service in addition to the inpatient admission are, in effect, submitting duplicate claims for the outpatient services. We have identified 4,660 hospitals that submitted improper billings for such outpatient services. These hospitals are given the opportunity to enter settlements with the Government under which their financial exposure is substantially less than if litigated under the Federal Civil False Claims Act. One of the most important parts of this project is the stipulation in each settlement agreement that each hospital will assure compliance with proper billing for future services. The total anticipated recovery under this nationwide project is approximately $90 million to $110 million over the next 2 years.

Exaggerated losses. When hospitals are sold, Medicare uses a system called the Recapture Program to account for gains and losses during the sale of depreciable assets. If the hospital sells for a profit (anything over its original value less depreciation) Medicare shares in the profit. If the hospital sells for a loss, Medicare shares in the loss. We are finding that sales are being artificially structured to report losses; to minimize profits in order to maximize Medicare payments at the time of the sale; or to minimize Medicare's recapturing of a portion of the profit.

Managed Care. Also included in this category of vulnerable program areas is managed care, which has grown rapidly in recent years to include 4.9 million Medicare beneficiaries, or 13 percent of the total Medicare population. Our studies have shown that most beneficiaries are satisfied with the care they receive from their Medicare managed care providers. However, we have found some indications that some sicker patients, such as dialysis patients and disabled persons, are far less satisfied and leave these programs at higher rates than other beneficiaries. In a 1991 study of health maintenance organization (HMO) marketing practices in Florida, we found that most beneficiaries did not feel pressured by sales staff and understood the differences between fee-for-service and managed care arrangements. A few marketing abuses were found such as sales staff targeting illiterate or otherwise limited beneficiaries and talking them into changing from one HMO to another without the beneficiary fully understanding what they had done. For example, one beneficiary said a driver picked him up to keep a medical appointment at his HMO. However, the driver took the beneficiary to a new HMO, whereupon he was enrolled in that HMO plan. The beneficiary thought he was merely keeping his appointment with is current HMO. A substantial number of beneficiaries did not understand that they had a right to back out of managed care if they were not satisfied. Subsequently, we have found weaknesses with appeal and grievance processes and have uncovered instances of false billings for institutionalized, dialysis, or Medicaid eligible Medicare beneficiaries on whose behalf the Medicare health maintenance organizations are entitled to a higher rate of reimbursement than other members.

Other Vulnerable Areas. Physicians billing for services not rendered or not needed is a continuing problem. For example, a urologist was recently sentenced to 24 months in prison for

submitting false claims for complex procedures he did not perform. He will be excluded from Medicare for 10 years because of aggravating circumstances: i.e., he performed invasive procedures such as visual examinations of the bladder and urethra and assessments of the bladder's neuromuscular function which he admitted were not medically necessary. He has surrendered his medical license.

We are also becoming increasingly concerned about ambulance services. The Medicare bill has now reached $2 billion per year. We have seen a continuous stream of fraud cases involving false or inflated claims and billing for higher levels of service than provided by ambulance companies. We are also just now seeing a consolidation of that industry into the hands of a few large corporations. Recently, an ambulance company entered a global settlement of allegations that it billed the Government for nonallowable transportation services. The company agreed to forfeit $4.6 million in payments withheld by the Medicare carrier. Criminal investigation of several individuals is ongoing.

Management Authorities and Systems

Some of Medicare's most troublesome vulnerabilities stem not so much from the design of individual benefit categories, but from weaknesses in management authorities or ineffective information and control systems used by the Department to administer programs and monitor their cost and effectiveness. The following are examples of such weaknesses which we have observed over and over again in our work.

Enrollment of Providers. In my earlier discussion of durable medical equipment, I alluded to the need for stronger measures related to the enrollment of providers. This is true for almost all aspects of the Medicare program. One of the best ways to prevent Medicare fraud is to keep illegitimate providers from ever getting into the program.

This could be accomplished by mandating providers to supply social security numbers and, in the instances of entities, by supplying tax identification numbers. The Health Insurance Portability and Accountability Act also establishes a National Provider Identifier which will be used by all health care providers and will replace most provider numbers currently used by Medicare. This can lead to a significant improvement in our ability to identify providers, and we plan to monitor the implementation of this closely to ensure that there are adequate provisions to ensure the integrity of the system. However, I also need to stress to you today that the effectiveness of this new system may be limited by the statutory prohibition on the collection of Social Security numbers. We strongly recommend that the Congress authorize the collection of this information to ensure that fraudulent providers are identified and prevented from doing business with the Government.

Provider enrollment applications should be updated every 2 years. Other controls such as use of surety bonds and application fees to pay for on-site inspections and screening of applicants are also being considered as measures to strengthen the integrity of the system. In addition, changes are needed to prevent fraudulent providers from escaping the consequences of their illegitimate acts by declaring bankruptcy because of the fines imposed on them or disingenuously passing ownership of their companies on to family members or friends while continuing to manage the companies from behind the scenes.

Faster Decision Making. We all have had unsatisfactory experiences dealing with the complexity and size of our Government programs. Changing them is always difficult. In fact, the system of checks and balances of our government is designed in part to ensure that change occurs deliberately and cautiously. While we all can get frustrated with attempting to enact change, I can tell you that in fighting fraud and abuse, it is particularly disconcerting. In many respects, the Government is too slow to correct program deficiencies or close loopholes in the law which allow our programs to be abused. Program managers need more flexibility in running the programs in order to correct deficiencies before they result in millions of dollars being wasted. I would like to give you a couple of examples of this.

> Reimbursement rates. When we find that a particular service or piece of medical equipment is overpriced, the Health Care Financing Administration has to go through an elaborate rulemaking process to reduce the amount Medicare pays for that item. This process involves an independent review to determine that the price of the item is "inherently unreasonable," publication of a proposed rule in the Federal Register, followed by a response to public comments and the publication of a final rule in the Federal Register. This process can easily take 2 years. For example, in December 1992, we reported that Medicare fee schedules for blood glucose monitors were excessive. While the monitors could be purchased for $50 at a drug or grocery store, we found that the Medicare fee schedules nationwide ranged from $144 to $211. In response, HCFA issued a final rule in January 1995 which established a flat payment amount of $58.71, resulting in annual savings of $5 million.
>
> Coverage. The same process delays the implementation of decisions about which services or supplies to cover. For example, when we found that seat lift chairs were being aggressively marketed as a comfortable lounge chair, HCFA began the arduous, time consuming regulatory process needed to determine whether to withdraw coverage of this item. Fortunately, the Congress stepped in with legislation in 1989 to limit coverage to the seat lift mechanism only, and expenditures dropped from $122 million in 1988 to $14 million in 1991.

The Health Care Financing Administration needs more flexible and efficient authorities to make decisions about both prices and coverage.

Adequacy of Current Criminal and Civil Enforcement Measures

Last year we got a major boost in our efforts through the Fraud and Abuse Control Program, a key part of the Health Insurance Portability and Accountability Act. This program provides much needed resources, stronger enforcement tools, and a management structure to coordinate the efforts of numerous fraud fighting units of Federal, State, and local governments. The Fraud and Abuse Control Program is a creative and far-reaching program to root out fraud and abuse in the nation's health care system. It amounts to nothing less than an all out, pitched battle against health care fraud and abuse.

The program is under the joint direction of the Attorney General and the Secretary of Health and Human Services, working through the Inspector General. It is designed to provide a framework and resources to coordinate Federal, State, and local law enforcement efforts. It mandates a

comprehensive program of investigations, audits, and evaluations of health care delivery; authorizes new criminal, civil, and administrative remedies; requires guidance to the health care industry about potentially fraudulent health care practices; and establishes a national data bank to receive and report final adverse actions imposed against health care providers. The Act also provides an innovative mechanism to fund these new anti-fraud efforts, thereby assuring that needed resources are always available for the effort.

The Health Insurance Portability and Accountability Act envisions a fraud fighting program that coordinates the efforts of a broad array of law enforcement and health care agencies. And it authorizes funding to support the strengthening of their methods and the development of new detection and enforcement techniques. We have already taken aggressive steps to develop such partnerships and build a national team to combat health care fraud and abuse. The combined and organized efforts of our partners presents a formidable obstacle to wrongdoers in the form of an unprecedented, comprehensive, nationwide program of audits, investigations, program evaluations, and sanctions.

CONCLUSION

I appreciate the opportunity to appear before you today and share with you our report from the front lines of our battles against those who would defraud Medicare, and also to share with you our insights about vulnerabilities and problems facing us today. We appreciate your support for our efforts, and I welcome your questions.

STATEMENT
OF
CHARLES L. OWENS
CHIEF, FINANCIAL CRIMES SECTION
FEDERAL BUREAU OF INVESTIGATION

GOOD MORNING MADAM CHAIRMAN AND MEMBERS OF THE SUBCOMMITTEE.

THE FBI PLACES A HIGH PRIORITY ON INVESTIGATING HEALTH CARE FRAUD AND IS COMMITTED TO WORKING WITH THIS COMMITTEE AND ALL OF CONGRESS TO ENSURE THAT LAW ENFORCEMENT HAS THE NECESSARY TOOLS TO COMBAT THE HEALTH CARE CRIME CRISIS.

AS THE COMMITTEE IS AWARE, IN ADDITION TO PROVIDING NEW STATUTORY TOOLS TO COMBAT HEALTH CARE FRAUD, THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996, WHICH WAS PASSED BY THE LAST SESSION OF CONGRESS, SPECIFIED MANDATORY FUNDING TO THE FBI FOR HEALTH CARE FRAUD ENFORCEMENT. THE LAW PROVIDED THE FBI WITH $47 MILLION IN FY97 FOR ITS HEALTH CARE FRAUD EFFORTS, UP FROM $38 MILLION IN FY96. THE FBI USED THIS ENHANCEMENT, IN LARGE PART, TO FUND AN ADDITIONAL 46 AGENT AND 34 PROFESSIONAL SUPPORT POSITIONS FOR HEALTH CARE FRAUD AND TO CREATE SEVERAL NEW DEDICATED HEALTH CARE FRAUD SQUADS.(SEE CHART 1 ATTACHED). THIS INCREASE IN PERSONNEL RESOURCES BROUGHT THE NUMBER OF FBI AGENTS ADDRESSING HEALTH CARE FRAUD IN THE 2ND QUARTER OF FY97 TO THE EQUIVALENT OF 350 AGENTS AS COMPARED TO 112 IN 1992. (SEE CHART 2 ATTACHED). FUNDING IS SLATED TO INCREASE INCREMENTALLY TO THE YEAR 2003, WHEN IT WILL REACH $114 MILLION AND REMAIN AT THAT LEVEL EACH YEAR THEREAFTER. WITH THIS ADDITIONAL FUNDING, THE FBI WILL BE IN A POSITION TO CONTINUE TO INCREASE THE NUMBER OF AGENTS COMMITTED TO HEALTH CARE FRAUD INVESTIGATIONS. AS THE FBI HAS INCREASED THE NUMBER OF AGENTS ASSIGNED TO HEALTH CARE FRAUD INVESTIGATIONS, THE CASELOAD HAS INCREASED DRAMATICALLY FROM 591 CASES IN 1992, TO OVER 2300 CASES IN THE FIRST HALF OF 1997. WE ANTICIPATE THIS TREND TO CONTINUE. (SEE CHART 3 ATTACHED). THE

FBI CASELOAD IS DIVIDED BETWEEN THOSE HEALTH PLANS RECEIVING GOVERNMENT FUNDS AND THOSE THAT ARE PRIVATELY FUNDED (SEE CHART 4 ATTACHED). CRIMINAL HEALTH CARE FRAUD CONVICTIONS RESULTING FROM FBI INVESTIGATIONS HAVE RISEN FROM 116 IN 1992, TO 475 IN 1996. (SEE CHART 5 ATTACHED).

NO SEGMENT OF THE HEALTH CARE SYSTEM IS IMMUNE FROM FRAUD. THIS MORNING I WOULD LIKE TO DISCUSS BRIEFLY THREE AREAS OF THE HEALTH DELIVERY SYSTEM WHICH FBI INVESTIGATIONS HAVE SHOWN TO BE PARTICULARLY SUSCEPTIBLE TO FRAUD: LABORATORY BILLINGS, HOME HEALTH CARE, AND DURABLE MEDICAL EQUIPMENT, PROSTHETICS, ORTHOTICS, AND SUPPLIES (DMEPOS).

EIGHT MONTHS AGO, DAMON CLINICAL LABORATORIES INC. AGREED TO PAY THE FEDERAL GOVERNMENT $119 MILLION IN CIVIL AND CRIMINAL PENALTIES FOR SUBMITTING FALSE CLAIMS TO THE MEDICARE PROGRAM AND A NUMBER OF MEDICAID PROGRAMS. IN NOVEMBER OF LAST YEAR, THE LABORATORY CORPORATION OF AMERICA AGREED TO PAY THE FEDERAL GOVERNMENT $182 MILLION IN CIVIL PENALTIES ASSOCIATED WITH SUBMITTING FALSE CLAIMS FOR MEDICALLY UNNECESSARY TESTS. AS PART OF THIS AGREEMENT, ALLIED CLINICAL LABORATORIES, A LABCORP SUBSIDIARY, PLED GUILTY TO A CRIMINAL CHARGE AND IS TO PAY A $5 MILLION CRIMINAL FINE. IN FEBRUARY OF THIS YEAR, SMITHKLINE BEECHAM CLINICAL LABORATORIES INC. AGREED TO PAY $325 MILLION TO SETTLE FRAUD CHARGES.

THESE MULTI-AGENCY INVESTIGATIONS AND SETTLEMENTS WERE THE RESULT OF THE COOPERATIVE EFFORTS FROM A NUMBER OF AGENCIES AND RESULTED IN SIGNIFICANT RESTORATIONS TO THE MEDICARE AND MEDICAID

TRUST FUNDS. THE FRAUD SCHEMES INCLUDE BUNDLING CERTAIN LAB TESTS WITH BLOOD PANELS, CAUSING PHYSICIANS TO ORDER TESTS THAT WERE NOT MEDICALLY NECESSARY, BILLING FOR HEMOGRAM INDICES EACH TIME A COMPLETE BLOOD COUNT WAS ORDERED, "CODE JAMMING" ON SCREENING TESTS TO ENSURE MEDICARE PAYMENT, AND PROVIDING INDUCEMENTS TO PHYSICIANS TO OBTAIN THEIR MEDICARE BUSINESS. INVESTIGATIONS INTO OTHER ALLEGATIONS INVOLVING THE LABORATORY INDUSTRY ARE CONTINUING.

A PENNSYLVANIA MAN WAS RECENTLY INDICTED ON FORTY COUNTS FOR VIOLATING THE CONSPIRACY, MAIL FRAUD, WIRE FRAUD, AND MONEY LAUNDERING STATUTES IN A SCHEME WHICH ENABLED HIM TO RECEIVE OVER $7 MILLION IN MEDICARE PAYMENTS. THE DEFENDANT OBTAINED A PROVIDER NUMBER AND BILLED FOR NON-INVASIVE LABORATORY SERVICES SUCH AS X-RAYS AND OTHER TESTING WHEN IN FACT HIS COMPANY HAD NO EMPLOYEES AND NO ONE WAS EVER TESTED. THE SUBJECT'S HOME, VEHICLES, AND BANK ACCOUNTS ARE IN THE PROCESS OF BEING FORFEITED.

THE HOME HEALTH INDUSTRY HAS GROWN TREMENDOUSLY DURING THE LAST FEW YEARS. IN 1993, HOME HEALTH AGENCIES WERE REIMBURSED BY MEDICARE IN THE AMOUNT OF $9.7 BILLION FOR SERVICES PROVIDED TO 2.8 MILLION MEDICARE BENEFICIARIES. BY 1996, MEDICARE PAID $17.2 BILLION TO PROVIDERS OF HOME HEALTH CARE FOR SERVICES RENDERED TO 3.8 MILLION BENEFICIARIES. THE NUMBER OF HOME HEALTH AGENCIES BILLING MEDICARE HAS GROWN FROM JUST OVER 7,000 IN 1993, TO AN ESTIMATED 9,500 IN 1996.

INVESTIGATIONS CONDUCTED BY THE DEPARTMENT OF HEALTH AND

HUMAN SERVICES, OFFICE OF INSPECTOR GENERAL, AND THE FBI HAVE UNCOVERED FRAUD SCHEMES IN THIS AREA INVOLVING COST REPORTING FRAUD; BILLING FOR SERVICES NOT RENDERED; UP-CODING VISITS TO A HIGHER REIMBURSEMENT CODE, SUCH AS A SKILLED NURSING VISIT; AND BILLING FOR SERVICES RENDERED TO PERSONS NOT "HOME BOUND" AS REQUIRED BY MEDICARE. A NUMBER OF FACTORS MAY CONTRIBUTE TO THE HIGH RATE OF FRAUD DETECTED IN THE HOME HEALTH INDUSTRY. LESS THAN 4% OF THE AGENCIES RECEIVE ON-SITE AUDITS BY MEDICARE CONTRACTORS AND THE BENEFICIARIES ARE NOT REQUIRED TO MAKE A CO-PAYMENT, MAKING IT LESS LIKELY THAT A BENEFICIARY WILL COMPLAIN ABOUT THE EXTENT OF SERVICE OR WHAT'S BEING BILLED TO MEDICARE.

DURING AN AUDIT BY THE MEDICARE BRANCH OF BLUE CROSS AND BLUE SHIELD OF IOWA, KNOWN AS IASD HEALTH SERVICES CORP., NUMEROUS DISCREPANCIES WERE DISCOVERED IN THE COST REPORTS OF ONE HOME HEALTH AGENCY. A SUBSEQUENT INVESTIGATION BY THE FBI REVEALED THAT THIS HOME HEALTH AGENCY HAD SUBMITTED FALSE INVOICES IN SUPPORT OF THEIR COST REPORT. ALSO, CONTRACTS FOR SERVICES TOTALING OVER $250,000 WERE ISSUED TO FAMILY MEMBERS AND FRIENDS, BUT NO ACTUAL SERVICES WERE RENDERED. FURTHER, PAYROLL CHECKS IN EXCESS OF $500,000 WERE ISSUED TO INDIVIDUALS NOT ON THE EMPLOYEE LIST. THE OWNERS OF THIS AGENCY, WHO WERE REIMBURSED BY MEDICARE IN EXCESS OF $10 MILLION FROM 1993 TO 1995, SUBSEQUENTLY PLED GUILTY AND ARE PRESENTLY IN A FEDERAL PRISON.

ANOTHER AREA OF HEALTH CARE THAT HAS BEEN SHOWN TO BE PARTICULARLY VULNERABLE TO FRAUD IS DURABLE MEDICAL EQUIPMENT.

RECENTLY, FIVE MIDWEST RESIDENTS PLED GUILTY TO RACKETEERING CHARGES IN CONNECTION WITH MORE THAN $25 MILLION IN FRAUDULENT BILLINGS TO MEDICARE THROUGH THE MARKETING OF DURABLE MEDICAL EQUIPMENT TO NURSING HOMES. THE DEFENDANTS WERE CHARGED WITH RECEIVING MEDICARE REIMBURSEMENT FOR PRODUCTS THEY DID NOT PROVIDE, RECEIVING PAYMENT FOR NON-REIMBURSABLE SUPPLIES, PROVIDING UNNECESSARY ITEMS TO PATIENTS, MISREPRESENTING THE QUANTITIES OF SUPPLIES ACTUALLY PROVIDED, AND ENGAGING IN BILLING ACTIVITIES TO AVOID DETECTION BY THE MEDICARE CONTRACTOR. PART OF THE SCHEME INCLUDED ADDING UNNECESSARY ITEMS IN URINARY INCONTINENCE KITS AND MARKETING THOSE ITEMS TO NURSING HOMES FOR REIMBURSEMENT FROM MEDICARE. IN ADDITION TO THE POSSIBILITY OF SUBSTANTIAL PRISON TERMS, THE DEFENDANTS FACE FORFEITURE OF ILLEGAL PROCEEDS IN EXCESS OF $11 MILLION.

THE LIST OF SCHEMES AND TYPES OF FRAUD BEING PERPETRATED ARE VIRTUALLY ENDLESS. THE FUNDING PROVISIONS FROM THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 WILL ENABLE THE FBI TO ENHANCE ITS COMMITMENT TO THE FIGHT AGAINST THE HEALTH CARE FRAUD CRIME PROBLEM. I HAVE ATTEMPTED TO HIGHLIGHT WHAT WE PERCEIVE TO BE THE MAJOR PROBLEM AREAS AND WHAT THE FBI IS DOING TO ADDRESS THEM.

THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (THE ACT) ALSO ESTABLISHED THE HEALTH CARE FRAUD AND ABUSE CONTROL ACCOUNT WHICH PROVIDED FUNDING TO THE DEPARTMENT OF HEALTH AND HUMAN SERVICES AS WELL AS THE DEPARTMENT OF JUSTICE. THIS FUNDING INCREASE FOR THE DEPARTMENT OF JUSTICE PROVIDES

GREAT SUPPORT FOR THE DEPARTMENT'S DECISION, FROM APPROXIMATELY FIVE YEARS AGO, TO MAKE HEALTH CARE FRAUD PROSECUTION ONE OF ITS TOP PRIORITIES. THROUGH THE FUNDING PROVISIONS OF THIS ACT, THE DEPARTMENT WAS ABLE TO HIRE AN ADDITIONAL 90 ASSISTANT UNITED STATES ATTORNEYS (AUSAS), 60 CRIMINAL AND 30 CIVIL, TO SUPPORT HEALTH CARE FRAUD PROSECUTIONS. THE ASSIGNMENT OF THESE AUSAS TO VARIOUS DISTRICTS WAS CLOSELY COORDINATED WITH THE BUREAU'S STAFFING INCREASES AND WILL ENSURE ADEQUATE PROSECUTIVE SUPPORT FOR THE ANTICIPATED INCREASE IN CRIMINAL MATTERS UNDER INVESTIGATION.

THE ACT ALSO CREATED A FEDERAL HEALTH CARE FRAUD OFFENSE, WHICH COVERS ANY HEALTH CARE PLAN, WHETHER GOVERNMENT OR PRIVATELY FUNDED, AND EMPOWERS THE ATTORNEY GENERAL OR HER DESIGNEE TO ISSUE INVESTIGATIVE DEMANDS TO OBTAIN RECORDS PERTAINING TO FEDERAL CRIMINAL HEALTH CARE OFFENSES. RECORDS OBTAINED PURSUANT TO THIS METHOD ARE NOT SUBJECT TO THE SAME CONSTRAINTS APPLICABLE TO RECORDS OBTAINED THROUGH THE USE OF A GRAND JURY SUBPOENA.

DESPITE THE GREAT STRIDES MADE BY THE LAST SESSION OF CONGRESS, ADDITIONAL LEGAL TOOLS ARE STILL NEEDED IF LAW ENFORCEMENT IS TO MAKE EVEN MORE OF AN IMPACT ON THIS ESTIMATED $100 BILLION A YEAR CRIME PROBLEM.

THE FBI CONCURS WITH THE DEPARTMENT OF JUSTICE THAT THERE SHOULD BE A LIBERALIZATION OF F.R.CR.P. 6(E) TO FACILITATE THE SHARING OF INFORMATION AMONG CRIMINAL AND CIVIL ATTORNEYS IN HEALTH CARE CASES. OFTEN, INVESTIGATIONS WHICH ARE INITIATED ON

COMPLAINTS OF CRIMINAL ALLEGATIONS FALL SHORT OF THE BURDEN OF PROOF REQUIRED TO SUSTAIN CRIMINAL CONVICTIONS AND THE APPROPRIATE REMEDY BECOMES CIVIL ENFORCEMENT. INFORMATION CURRENTLY OBTAINED THROUGH THE GRAND JURY CANNOT BE AUTOMATICALLY USED BY CIVIL ATTORNEYS, ABSENT A COURT ORDER.

SECONDLY, WHILE SECTION 204 OF THE ACT EXTENDS TITLE 42 CRIMINAL PROVISIONS RELATING TO KICKBACKS OF ALL HEALTH PLANS RECEIVING FEDERAL FUNDS, EXCEPT THE FEDERAL EMPLOYEES HEALTH BENEFIT PLAN (FEHBP), IT DOES NOT APPLY ILLEGAL REMUNERATION PROHIBITIONS TO THE PRIVATE HEALTH CARE INDUSTRY. CONGRESS HAS ALSO NOT INCLUDED VIOLATION OF THE ANTI-KICKBACK STATUTE IN THE DEFINITION OF FEDERAL HEALTH CARE OFFENSE. THUS, IN AN INVESTIGATION BASED SOLELY ON ILLEGAL KICKBACKS, THE NEW HEALTH CARE VIOLATIONS AND NEW PROCEDURAL TOOLS, SUCH AS INVESTIGATIVE DEMAND AUTHORITY AND INJUNCTIVE RELIEF, WILL NOT BE APPLICABLE.

STATISTICAL ANALYSIS OF BILLING DATA TYPICALLY REFLECTS HIGH USAGE PEAKS DURING CERTAIN TIME PERIODS FOR VARIOUS PROCEDURE CODES. REIMBURSEMENT FOR THESE PROCEDURES OR TESTS REQUIRE CERTIFICATION FROM A MEDICAL PROVIDER STATING THE PROCEDURE OR TEST WAS MEDICALLY NECESSARY. TYPICALLY, AFTER LAW ENFORCEMENT ACTIVITY IS INITIATED BASED PARTLY ON THE STATISTICALLY ABERRANT USAGE OF A PARTICULAR CODE, USAGE DECREASES AND ANOTHER PROCEDURE EXHIBITS HIGHER THAN NORMAL USAGE. ONE CANNOT HELP BUT ASSUME THAT THESE ABERRANT BILLING PATTERNS ARE DUE IN PART TO MONETARY INCENTIVES OF PROVIDERS TO CERTIFY THAT THE TESTS OR PROCEDURES WERE MEDICALLY NECESSARY. WHEN THE MEDICAL JUDGEMENT OF

PROVIDERS BECOMES OBSCURED BY THE MOTIVE FOR PROFIT, ALL AMERICANS SEEKING MEDICAL CARE BECOME POTENTIAL VICTIMS. THE FBI AND OTHER DEPARTMENT OF JUSTICE COMPONENTS WOULD SUPPORT AN AMENDMENT TO THE FEDERAL CRIMINAL CODE TO CREATE A NEW GENERALIZED OFFENSE AGAINST KICKBACKS PAID IN CONNECTION WITH A "HEALTH CARE BENEFIT PROGRAM" AS DEFINED IN 18 U.S.C. SEC. 24 (B). THIS PROVISION WOULD FILL THE GAP IN THE LAW BY EXTENDING FEDERAL ANTI-KICKBACK CRIMINAL SANCTIONS TO ALL HEALTH CARE BENEFIT PROGRAMS, PUBLIC AND PRIVATE.

THAT CONCLUDES MY PREPARED REMARKS AND AT THIS TIME I WOULD BE PLEASED TO ANSWERS ANY QUESTIONS THAT YOU MAY HAVE.

United States General Accounting Office

GAO

Testimony

Before the Permanent Subcommittee on Investigations,
Committee on Governmental Affairs, U.S. Senate

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MEDICARE

Control Over Fraud and Abuse Remains Elusive

Statement of Leslie G. Aronovitz, Associate Director
Health Financing and Systems Issues
Health, Education, and Human Services Division

GAO/T-HEHS-97-165

Medicare: Control Over Fraud and Abuse Remains Elusive

Madam Chairman and Members of the Subcommittee:

We are pleased to be here today as you discuss the problem of fraud and abuse in the Medicare program. Because Medicare is one of the largest, most expensive programs in the federal budget, its spending has been the subject of numerous legislative proposals in recent years by the Congress and the administration. In fiscal year 1996, Medicare expenditures totaled about $200 billion, and the program's Hospital Insurance Trust Fund is expected to be depleted by 2001. At the same time, millions of dollars are being spent inappropriately because of the fraudulent and abusive billing practices of health care providers, thus prompting congressional concern about program vulnerabilities.

My comments today will focus on both the fee-for-service and managed care programs. Specifically, I would like to highlight the anti-fraud-and-abuse tools available to Medicare; the extent to which and how effectively they are used by the Health Care Financing Administration (HCFA), the agency responsible for administering the program; and recent legislative activity aimed at improving program safeguards.

The information I am presenting today is based on recent GAO studies and the three High Risk Series reports on Medicare we have issued since 1992. The high-risk reports are the products of GAO's special effort, begun in 1990 and supported by the Senate Committee on Governmental Affairs, to review federal program areas identified as high risk because of vulnerabilities to waste, fraud, abuse, and mismanagement. (See Related GAO Products at the end of this statement.)

In brief, we selected Medicare as one of the initial programs to be included in our high-risk efforts because of the program's size, complexity, and rapid growth. In addition, HCFA's efforts to fight Medicare fraud and abuse have not been adequate to prevent substantial losses because the tools available over the years have been underutilized or not deployed as effectively as possible.

Because of budget constraints, the number of reviews of claims and related medical documentation and the site audits of providers' records have dwindled significantly. This means, for example, that a home health provider has only a slim chance of having its claims, its year-end cost reports, or its actual provision of services carefully scrutinized by Medicare. In addition, HCFA's management of its claims processing controls and Medicare's automated information systems has been unsatisfactory.

As a result, Medicare's information systems and the staff monitoring claims have been less than effective at spotting indicators of potential fraud, such as suspiciously large increases in reimbursements, improbable quantities of services claimed, or duplicate bills submitted to different contractors for the same service or supply. Because of acknowledged system weaknesses, HCFA is in the process of acquiring a new multimillion-dollar automated system called the Medicare Transaction System (MTS). MTS is intended to replace Medicare's multiple automated systems and is expected to enhance significantly its fraud and abuse detection capabilities. However, HCFA has not effectively managed the process for acquiring this system. Now schedule delays and growing cost projections—from a $151 million estimate made in 1992 to about a $1 billion estimate this year—have forced HCFA to halt much of the system's development while the agency reassesses its acquisition plans.

Less than adequate oversight has also resulted in little meaningful action taken against Medicare health maintenance organizations (HMO) found to be out of compliance with federal law and regulations. Other than requiring corrective action plans, HCFA has not sanctioned poor performing HMOs, using such tools as excluding these HMOs from the program, prohibiting continued enrollment until deficiencies are corrected, or notifying beneficiaries of the HMOs cited for violations. Accumulated evidence of in-home sales abuses coupled with high rates of rapid disenrollment for certain HMOs also indicate that some beneficiaries are confused about or are being misled during the enrollment process and are dissatisfied once they become plan members. In addition, consumer information that could help beneficiaries distinguish the good plans from the poor performers is not made publicly available, limiting the ability of beneficiaries to make informed choices about competing plans. This in turn limits the ability of consumer choice to drive out poor quality.

Recent and proposed legislation—chiefly the Kassebaum-Kennedy legislation, also known as the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and the budget reconciliation legislation now being considered by the Congress—refocus attention on various aspects of Medicare fraud and abuse. The implementation of the enacted provisions, such as additional funding for special antifraud initiatives and the promise of proposed legislation, such as the authority to prevent all convicted felons from becoming Medicare providers, offer the potential to reduce Medicare losses attributable to unwarranted payments. But HCFA's history of lengthy delays in implementing legislation gives cause

for concern about whether the authorities granted will be acted on promptly and effectively.

Background

Established under the Social Security Amendments of 1965, Medicare is a two-part program: "hospital insurance," or part A, which covers inpatient hospital, skilled nursing facility, hospice, and home health care services; and "supplementary medical insurance," or part B, which covers physician and outpatient hospital services, diagnostic tests, and ambulance and other health services and supplies. Medicare falls under the administrative jurisdiction of HCFA, within the Department of Health and Human Services (HHS). HCFA administers both traditional fee-for-service Medicare and HMOs under contract that are permitted to enroll Medicare beneficiaries.

Fee-for-Service Program

In 1996, Medicare's fee-for-service program covered almost 90 percent, or 35 million, of Medicare's beneficiaries. Physicians, hospitals, and other providers submit claims to Medicare to receive payment for services they have provided to beneficiaries. HCFA administers Medicare's fee-for-service program largely through a network of about 70 claims processing contractors, that is, insurance companies—like Blue Cross and Blue Shield plans, Mutual of Omaha, and CIGNA—that process and pay Medicare claims. In fiscal year 1996, contractors processed about 800 million Medicare claims.

As Medicare contractors, these companies use federal funds to pay health care providers and beneficiaries and are reimbursed for their administrative costs incurred in performing the work. They are also responsible for the payment safeguard activities intended to protect Medicare from paying inappropriately.[1] The contractors have broad discretion in conducting these activities, resulting in significant variations across contractors in implementing payment safeguards.

Generally, intermediaries are the contractors that handle claims submitted by "institutional providers" (hospitals, skilled nursing facilities, hospices, and home health agencies); carriers are those handling claims submitted by physicians, laboratories, equipment suppliers, and other practitioners.

[1]Although under section 202 of HIPAA, the HHS Secretary is authorized to enter into contracts with entities other than its current contractors to perform payment safeguard activities, HCFA has not yet awarded any contracts of this type.

Managed Care Program

Medicare's managed care program covers a growing number of beneficiaries—nearly 5 million at the end of 1996—who have chosen to enroll in an HMO to receive their medical care rather than obtaining services from individual providers. The managed care program, which is funded from both the part A and part B trust funds, consists mostly of risk contract HMOs that enrolled about 4 million Medicare beneficiaries as of the end of 1996.[2] These HMOs are paid a monthly amount, fixed in advance, by Medicare for each beneficiary enrolled rather than for each service provided. In this sense, the HMO has a "risk" contract because, regardless of what it spends for each enrollee's care, the HMO assumes the financial risk of providing all needed health care in return for the payments received. HMOs profit if their costs of providing services are lower than the predetermined payment but lose if their costs are higher than the Medicare payment.

Medicare Fraud

Fraud and abuse encompass a wide range of improper billing practices that include misrepresenting or overcharging with respect to services delivered. Both result in unnecessary costs to Medicare; but a fraud conviction requires proof of intent to defraud. Abuse typically involves actions that are inconsistent with Medicare billing rules and policies. As a practical matter, whether and how a wrongful act is addressed can depend on the size of the financial loss incurred and the quality of the evidence establishing intent. For example, small claims are generally not pursued as fraudulent because of the cost involved in investigation and prosecution.

The pursuit of fraud often begins with the contractors, which conduct reviews of submitted claims and respond to beneficiary complaints. They develop cases for referral to the HHS Inspector General for possible criminal or civil prosecution and administrative sanction. Potential fraud cases referred to the Inspector General require careful documentation by the contractor, entailing data analyses, claims audits, interviews with patients, and reviews of medical records.

Inspector General investigations can involve, among other things, additional interviews or analyses of medical records, and subpoena of financial records. If satisfied that the evidence warrants prosecution, the Inspector General forwards the case to a U.S. Attorney, within the Department of Justice. The U.S. Attorney then decides whether to accept

[2]Other Medicare managed care plans include cost contract HMOs and health care prepayment plans. Cost contract HMOs allow beneficiaries to choose health services from their HMO network or outside providers. Health care prepayment plans cover only part B services. Together, both types of plans enroll fewer than 2 percent of the Medicare population.

the case for prosecution. If an indictment, and finally, a conviction are obtained, further work is necessary to establish administrative sanctions and recover overpayments. Thus, although the mechanics to pursue Medicare fraud are in place, the high level of resources and interagency coordination required for case development can stall the pursuit of a case at many junctures and delay the resolution of a case for many years.

Medicare's Anti-Fraud-and-Abuse Efforts Consist Largely of Contractors' Payment Safeguards

HCFA relies on payment safeguards that consist largely of contractors' efforts to detect improprieties both before and after claims have been paid. In addition to complaints contractors receive from beneficiaries, detection efforts include prepayment reviews of providers' claims, and postpayment analyses, such as reviews of claims data and audits of provider costs. (See table 1.)

Table 1: Medicare's Controls to Detect Inappropriate Payments

Control	How it works
Leads from beneficiaries	Beneficiaries use Explanation of Medicare Benefits to alert Medicare of claims for services not provided, suspiciously high charges, or other indications of potential fraud.
Prepayment review	Computer edits check claims for compliance with such administrative requirements as the submission of all necessary information. Computer edits automatically deny claims that are duplicates of others already processed by that system. Computer screens suspend for manual review claims that do not appear to comply with medical necessity or coverage criteria.
Postpayment review	**Focused medical review**. Provider-targeted: Examining historical data, analysts compare providers' claims against those of their peers to identify high billers; past or future claims of high billers may be targeted for more extensive review. Service-targeted: Analysts examine expenditure data to identify medical services for which spending has been unusually high; past or future claims for these services may be subjected to more intensive reviews. **Comprehensive claims audit**. Reviewers examine in greater depth providers' billings found through leads from beneficiaries, focused medical review, or other sources to show irregularities. **Audit of cost reports**. Auditors verify the reasonableness of costs reported annually by institutional providers that are reimbursed on a cost basis.

Beneficiary Leads Generated From Payment Notices

The Explanation of Medicare Benefits (EOMB), which is a notice to beneficiaries detailing the services their provider billed for and Medicare payment decisions, is one type of payment safeguard. Many fraud cases begin with beneficiary calls to Medicare contractors, HCFA, the HHS Inspector General, the Federal Bureau of Investigation, state licensing agencies, and professional associations. These calls, officially termed complaints, are often triggered by EOMBs that show providers' bills for services never received, items never ordered, or suspiciously high charges for services or supplies received.

Prepayment Claims Screening

One of Medicare's key payment safeguard activities—performed by the claims processing contractors—is the prepayment screening of claims for compliance with administrative billing procedures and medical coverage policies. Edits and screens are programmed into claims processing software that trigger the suspension of incomplete or erroneous claims. For example, if a provider's billing number or beneficiary identification number is incomplete or otherwise incorrect, the computer automatically holds the claim until the data are corrected. Edits automatically deny duplicate claims. Screens will also halt processing when claims do not meet certain medical necessity or coverage conditions for payment. For example, a screen developed for echocardiography might suspend the processing of a claim for which the documented diagnosis was indigestion; in such a case, the claim would receive further review by contractor staff.

Postpayment Review

Another payment safeguard performed by contractor staff is postpayment review, which consists of efforts to detect irregularities. These efforts include (1) focused medical reviews, in which an examination of claims data focuses on either the billings of a particular provider or the expenditures for a particular service; (2) comprehensive audits of claims submitted by suspect providers; and (3) audits of providers' cost reports. Postpayment reviews can lead to the strengthening of payment policies that in the future will disallow or reduce unwarranted Medicare reimbursements for certain services.

Focused medical reviews involve reviewers examining claims data to find patterns that deviate from a norm. For example, they look for aberrancies in an individual provider's billing patterns by profiling, or identifying providers who bill for many more services per patient than their peers. Reviewers also look for aberrancies in expenditure data for a specific service or procedure largely by comparing the total amounts the

contractor spent for a particular service with spending in previous periods and with other contractors' spending for that service. The outcome of focused medical reviews can include more comprehensive reviews, also called audits, of providers' claims.

Claims audits are typically conducted for providers whose billings have shown irregularities. In these cases, contractors review a sample of claims for the provider's patients to determine whether services were appropriate—that is, medically necessary, covered by Medicare, and actually provided—and whether they were billed in compliance with Medicare rules. Audits are resource-intensive, often involving medical record reviews and patient and provider interviews. If audits disclose that Medicare has paid for unnecessary or inappropriate services, the contractor attempts to recover overpayments.

Focused medical review also generates the information contractors need to decide which services need medical review policies, which in turn typically serve as the basis for developing a computerized medical necessity screen, as discussed earlier. With the exception of some national policies, contractors develop their own medical review policies to address "local" payment issues. For example, after examining several years of data on spending for foot care services, a contractor determined that total spending for foot care services increased fourfold—from about $470,000 to about $1.8 million in a 3-year period. From this and other postpayment review information, the contractor developed a medical review policy covering foot care under certain conditions. This policy served as the basis for the contractor's development of a computer software screen for foot care services. Within a year, the contractor's payments for foot care procedures dropped to about $620,000, or a third of what had been paid the previous year.

Audits of cost reports submitted by providers paid under cost-based reimbursement are another postpayment review tool. Such providers—including hospital outpatient departments, skilled nursing facilities, and home health agencies—are reimbursed not on the basis of a fee schedule or the charge for a service but on the basis of the "reasonable" cost to provide the service.

Reimbursement to such institutional providers occurs in several steps. First, Medicare contractors make "interim" payments based on the provider's historical costs and current cost estimates. These payments help defray the ongoing costs of providing services to Medicare

beneficiaries. Second, at the end of each year, the providers submit reports that detail their operating costs throughout the preceding year and specify the share related to the provision of Medicare services. Using this information, intermediaries make interim adjustments to the payments made to the provider. Third, the intermediary can conduct either "desk audits" or more detailed reviews of the cost reports, including "field audits," to determine the appropriate final payment amounts.

Budget Constraints Have Weakened Efforts to Review Claims, Deter Abuse

Over the last 7 years, HCFA and its claims processing contractors have struggled to carry out critical claims review and provider audit activities with a budget that, on a per-claim basis, was declining substantially. For example, between 1989 and 1996, the number of Medicare claims climbed 70 percent to over 800 million, while during that same period, claims review resources grew less than 11 percent. Adjusting for inflation and claims growth, the amount contractors could spend on review shrank from 74 cents to 48 cents per claim. (See fig 1.1.)

The deterioration of Medicare's controls over home health payments exemplifies the effect of the inadequate funding of payment safeguards. Between 1988 and 1996, Medicare spending for home health care grew from $2.1 billion to $18 billion and by the year 2000 is projected to exceed $21 billion (see fig. 1.2). Along with increasing expenditures, the number of home health agencies has also increased—from about 5,800 to over 9,000.

However, as we reported in 1996, Medicare's review of home health claims greatly decreased in the 1990s, despite the dramatic rise in home health care expenditures.[3] Because of budgetary constraints in recent years, contractors' reviews of home health claims plummeted from 62 percent in 1987 to a target of 3 percent in 1996.[4] The infrequency of the intermediaries' medical review of claims and limited physician involvement in overseeing home health agencies' plans of care have made it nearly impossible to determine whether the beneficiary receiving home health services qualified for the benefit, needed the care being delivered, or even received the services being billed to Medicare. Also, because of the small percentage of claims selected for review, home health agencies that billed for noncovered services are much less likely to be identified than was the case a decade earlier.

[3]Medicare: Home Health Utilization Expands While Program Controls Deteriorate (GAO/HEHS-96-16, Mar. 27, 1996).

[4]Because the 3-percent target applied to all part A claims, the actual proportion of home health claims reviewed, which are a subset of part A claims, could actually be as low as 1 percent.

Similarly, the percentage of cost reports audited has declined; between 1991 and 1996, the chances that any institutional provider's cost report would be subject to a detailed review fell from about 1 in 6 to about 1 in 13. Because of the time needed to schedule and conduct audits, intermediaries can take 2 years or more to reach a final settlement. Tentative settlements that differ substantially from the amount ultimately determined to be due a provider cause underpayments or excessive payments that can remain outstanding for 2 years or more.

Concern about home health fraud and abuse is not new. Nearly two decades ago, HCFA began gathering information that this Subcommittee used to launch a review in 1981 of certain home health agencies operating in the Chicago metropolitan area. The findings and recommendations of the Subcommittee's 1981 report still resonate today. Among the recommendations made in 1981, several are particularly germane in light of current anti-fraud-and-abuse legislative activity, namely the Kassebaum-Kennedy legislation, and budget reconciliation provisions currently being considered by both houses of Congress:

- **The Subcommittee recommended not reducing intermediaries' budgets for auditing home health agencies to keep pace with program growth.** Medicare payment safeguard funding nevertheless did decline since 1989 until the passage of the Kassebaum-Kennedy legislation, which now ensures stable funding for program safeguards through 2003 and allows HCFA to count on stable funding in the coming years. However, per-claim expenditures for medical review and other controls will remain below the 1989 level after adjusting for inflation.
- **The Subcommittee noted that the government had no viable mechanism by which it could recoup overpayments.** In a report just released, we suggested that the Congress consider directing HCFA to start a demonstration that would assess home health agencies found to be habitual abusive billers for the costs of performing the follow-up audit work required to estimate overpayment amounts.[5]
- **The Subcommittee recommended that, to recoup overpayments, HCFA regulations require bonding of new agencies and agencies found to be habitual abusers and that HCFA expedite its promulgation of these regulations.** The regulations, however, were never finalized. The budget reconciliation bill proposes that certain providers billing Medicare, including home health agencies, post a surety

[5]See Medicare: Need to Hold Home Health Agencies More Accountable for Inappropriate Billings (GAO/HEHS-97-108, June 13, 1997).

bond for at least $50,000. This would make bonding a statutory requirement rather than an option left to HCFA's discretion.

Management Problems Also Affect Payments and Operations

Independent of the question of adequate funding is the issue of whether available safeguard dollars are being used as effectively as possible. HCFA has not taken full advantage of the controls contractors could use to screen for inappropriate claims. Moreover, despite deficiencies that might have been corrected in Medicare's current claims processing systems, HCFA has concentrated its management efforts on the development of a new system.

HCFA Has Not Routinely Made Available to Contractors Information on Effective Payment Controls

One chronic problem is that HCFA has not coordinated contractors' payment safeguard activities. For example, as was planned when the program was set up, part B carriers establish their own medical policies and screens, which are the criteria used to identify claims that may not be eligible for payment. Certain policies and the screens used to enforce them have been effective in helping some Medicare carriers avoid making unnecessary or inappropriate payments. However, the potential savings from having these policies and screens used by other carriers have been lost, as HCFA has not adequately coordinated their use among carriers. For example, as we reported in 1996, for just 6 of Medicare's top 200 most costly services in 1994, the use of certain carriers' medical policy screens by all of Medicare's carriers could have saved millions to hundreds of millions of dollars annually.[6] However, HCFA has not led in this area and the opportunity to avoid significant Medicare expenditures has been lost. (See fig. I.3.)

Information Management Problems Slow Efforts to Uncover Fraud and Abuse

HCFA's unsatisfactory management of a major systems acquisition project—MTS—has serious consequences for the ability of HCFA and its contractors to improve fraud and abuse monitoring activities. Ideally, as we reported in 1994,[7] a system like MTS would allow "on-line" claims processing, enabling contractors' systems to compare claims against other claims already submitted on behalf of the beneficiary, other claims submitted by the provider, and other claims for the same procedure or item. Without this capability, contractors' processing systems are not

[6]Medicare: Millions Can Be Saved by Screening for Overused Services (GAO/HEHS-96-49, Jan. 30, 1996).

[7]Medicare: New Claims Processing System Benefits and Acquisition Risks (GAO/HEHS/AIMD-94-79, Jan. 25, 1994).

programmed to screen for suspiciously large increases in reimbursements over a short period or improbable quantities of services claimed for a single day of care. The following examples cited in our previous work highlight the problem:

- In the fourth quarter of 1992, a Medicare contractor paid a supplier $211,900 for surgical dressing claims. For the same quarter a year later, the contractor paid the same supplier more than $6 million without becoming suspicious, despite the 2,800-percent increase in the amount paid.
- A contractor paid claims for a supplier's body jackets[5]—with no questions asked—that averaged about $2,300 per quarter for five consecutive quarters and then jumped to $32,000, $95,000, $235,000, and $889,000 over the next four quarters.
- A contractor reimbursed a clinical psychology group practice for individual psychotherapy visits of 45 to 50 minutes. Three psychologists in the group were billing for, and allegedly seeing, from 17 to 42 nursing facility patients per day. On many days, the leading biller of this group would have had to work more than 24 uninterrupted hours to provide the services he claimed.
- A contractor paid a podiatrist $143,580 for performing surgical procedures on at least 4,400 nursing facility patients during a 6-month period. For these services to be legitimate, the podiatrist would have had to serve at least 34 patients a day, 5 days a week.

In the last two cases cited, the contractors did not become suspicious until they received complaints from family members and beneficiaries themselves. This failure to discover unusual increases or unusually high amounts billed by a particular provider or for a particular service or supply item makes Medicare vulnerable to billing schemes.

MTS was also expected to, among other things, provide on-line access to beneficiary patient histories. Currently, Medicare's part A and part B systems are incompatible, making it difficult to spot schemes that involve billing both parts for the same service. Specifically, Medicare's discrete part A and part B processing systems are not designed to easily identify, on-line, all of the medical services and devices billed on behalf of an individual beneficiary. As a result, providers can improperly bill both parts with little danger of detection. In our 1995 review of medical supply payments, for example, we noted that the same supply item can be billed on behalf of an individual beneficiary to both an intermediary and a

[5]A body jacket is a custom-fitted spinal brace made of a rigid plastic material that conforms to the body and largely immobilizes it.

carrier.[9] We found instances of duplicate payments and noted that contractors lacked effective tests to determine whether both carriers and intermediaries paid for the same items. The HHS Inspector General has reported similar problems with payments for other services, such as ambulance transportation and diagnostic laboratory tests.[10]

The promise of MTS, however, could be delayed indefinitely. We recently reported that, in the 5 years between 1992 and 1997, estimated MTS development and implementation costs have jumped sevenfold from $151 million to about $1 billion.[11] This is symptomatic of various project management weaknesses we have previously reported, namely, that HCFA had not completely defined its requirements 2 years after awarding a systems development contract; HCFA's MTS development schedule has had significant overlap among the various system-development phases, increasing the risk that incompatibilities and delays will occur; and HCFA has not adequately managed MTS as an investment as evidenced by the lack of a satisfactory cost-benefit analysis or consideration of viable alternatives. After major problems and delays with its MTS development contract, HCFA announced on April 4, 1997, that it was halting all MTS fee-for-service software development for 90 days.

As a transitional step to MTS, HCFA has begun consolidating its three intermediary part A systems and six carrier part B systems into one part A claims system and one part B claims system. Having a single system for each part will allow better editing of claims, but it does not provide some of the benefits that were expected from MTS. Among these are the on-line capability to identify, before payment is made, whether (1) an item or service billed to part A has also been billed to part B and vice versa and (2) a billed item or service is consistent with the other items and services billed on behalf of an individual. The fate of MTS remains uncertain. HCFA officials said they would use the 90-day period to examine alternative methods for achieving their MTS goals.

[9]Medicare: Excessive Payments for Medical Supplies Continue Despite Improvements (GAO/HEHS-95-171, Aug. 8, 1995).

[10]Ambulance Services for Medicare End-Stage Renal Disease Beneficiaries: Medical Necessity, OEI-03-90-02130 (Washington, D.C.: HHS Office of Inspector General, Aug. 17, 1994); Ambulance Services for Medicare End-Stage Renal Disease Beneficiaries: Payment Practices, OEI-03-90-02131 (Washington, D.C.: HHS Office of Inspector General, Mar. 9, 1994); and Review of Separately Billable End-Stage Renal Disease Laboratory Tests, #A-01-96-00513 (Washington, D.C.: HHS Office of Inspector General, Oct. 1, 1996).

[11]For a detailed account of MTS costs and development problems, see Medicare Transaction System: Success Depends Upon Correcting Critical Managerial and Technical Weaknesses (GAO/AIMD-97-78, May 16, 1997).

Ineffective Oversight Leaves Beneficiaries Vulnerable to HMO Quality Problems

Some have argued that moving beneficiaries into managed care—that is, into a "claimless" environment—would eliminate problems of fraud and abuse. Unlike fee-for-service providers, physicians, hospitals, and other providers do not submit a per-service claim for reimbursement. Instead, they are paid by the HMO, which in turn is paid a monthly amount by Medicare for each beneficiary enrolled. However, our work shows that another set of problems exists in Medicare's managed care program, which enrolls more than 10 percent of Medicare's 39 million beneficiaries and is growing by about 85,000 beneficiaries per month.

Under managed care, where fixed monthly payments are made per beneficiary rather than per service, strategies to exploit Medicare are based on the incentive to underserve rather than overserve the beneficiary. Risk contract HMOs, Medicare's principal managed care option, can offer an attractive alternative to the traditional fee-for-service program because risk HMOs typically cover additional benefits and cost beneficiaries less money. However, in recent years, we have reported that some Medicare HMOs have not complied with federal standards and that HCFA's monitoring of these HMOs has been weak. For example, in 1995, we reported that, despite efforts to improve its HMO monitoring, HCFA conducted only paper reviews of HMOs' quality assurance plans, examining only the description rather than the implementation of HMOs' quality assurance processes.[12] Moreover, HCFA was reluctant to take action against noncompliant HMOs, even when there was a history of abusive sales practices, delays in processing beneficiaries' appeals of HMO decisions to deny coverage, or poor-quality care.

In a 1996 report, we discussed the value of releasing HMO performance data to Medicare beneficiaries as having the potential to reduce the occurrence of abusive marketing practices.[13] We found that cases developed from beneficiary complaints and other HCFA documentation revealed violations of Medicare regulations prohibiting certain marketing practices, such as activities that mislead, confuse, or misrepresent. Some examples follow:

- At least 20 beneficiaries were inappropriately enrolled in an HMO after attending the same sales seminar in August 1995. The beneficiaries thought they were signing up to receive more information but later discovered the sales agent had enrolled them in the plan.

[12]Medicare: Increased HMO Oversight Could Improve Quality and Access to Care (GAO/HEHS-95-155, Aug. 3, 1995).

[13]Medicare: HCFA Should Release Data to Aid Consumers, Prompt Better HMO Performance (GAO/HEHS-97-23, Oct. 22, 1996).

- In January 1995, a beneficiary was notified by his medical group before an appointment that he was now enrolled in another plan. The beneficiary had no idea how this could be, as he had not intended to change plans. Though the beneficiary signs with an "X," the new enrollment application was signed with a legible cursive signature. HCFA reenrolled the beneficiary in his former plan but took no action against the plan or the sales agent.
- One plan's marketing activities resulted in enrolling an 81-year-old woman. In the first months of membership, she visited her doctor, who was in the plan's provider network. When she later visited a non-network physician who had also been one of her regular providers, Medicare denied her claims because of her HMO enrollment. She then requested to disenroll and told HCFA that if she had understood the requirement to visit specific providers, she would not have enrolled in the HMO. HCFA disenrolled her from the plan effective with her use of non-network providers.

Despite many beneficiary complaints, HCFA does not take advantage of opportunities to use market forces to prod competitors to offer better quality services. HCFA collects, but does not systematically or routinely analyze, data on HMO activities that could be used to measure performance. Putting these data in the hands of beneficiaries could allow them to identify and select plans with better records and give HMOs incentives to improve their performance.

For example, in our 1996 study, we examined HCFA data on HMO disenrollments—rates at which Medicare beneficiaries quit their HMOs and join other plans or return to fee-for-service Medicare—as an indicator of beneficiary satisfaction. In the Miami market, for example, we found that in 1995 at one HMO only about 3 of every 25 beneficiaries disenrolled, whereas at another HMO more than 3 of every 10 beneficiaries disenrolled. We reported that these statistics, particularly in combination with complaint data, could help identify HMOs whose sales agents mislead or fail to adequately educate new enrollees. (See fig. I.4.)

In the case of one Florida HMO, for example, HCFA found—in 1991, 1992, 1994, and 1996—some combination of deficiencies in marketing, enrollment, quality assurance systems, grievance and appeals procedures, and access to health services. Despite the repeated findings of standards violations at this HMO, HCFA's strongest regulatory action was to require, after each inspection, a corrective action plan. HCFA did not provide Miami area beneficiaries with information on the inspection findings; at the same time, Medicare beneficiaries continued to enroll and disenroll in this plan.

Recent Legislative Activity Addresses Aspects of Medicare Fraud and Abuse

With the passage of the Kassebaum-Kennedy legislation known as HIPAA, the Congress recently provided important new resources and tools to fight health care fraud and abuse. To inform the Congress on the progress of HIPAA's implementation, we have begun monitoring HCFA's and the HHS Inspector General's efforts to implement the act. The Congress is currently considering additional provisions, as part of the budget reconciliation legislation, to further strengthen fraud reduction efforts.

Legislative Activity Related to Fee-for-Service Medicare

HIPAA ensures stable funding and provides for other antifraud efforts, while pending budget reconciliation legislation addresses additional aspects of fraud and abuse.

HIPAA

A key HIPAA provision ensures stable and gradually increasing funds earmarked for payment safeguard activities. HIPAA provides up to $440 million for program safeguards for this fiscal year, with budget increases scheduled in following years. For the year 2003 and beyond, HIPAA ensures funding of between $710 million and $720 million. However, as we have previously reported, by 2003, per-claim safeguard expenditures will be at about one-half the level of 1989 expenditures, after adjusting for inflation.[14]

Another HIPAA provision enables HCFA to contract with entities other than the insurers serving as Medicare intermediaries and carriers to conduct payment safeguard activities, including medical and utilization review and audits of cost reports. These contracts, intended to be awarded to entities with relevant expertise, may help improve the oversight of claims payment operations by enhancing data analysis capabilities and avoiding potential conflicts of interest with the contractor's private business. HCFA does not yet have a target date for awarding program safeguard contracts, nor has it finalized related plans to implement this HIPAA provision.

HIPAA also provides funding to HHS and the Department of Justice for combating health care fraud. For fiscal year 1997, the act provides an additional $104 million to these two departments, $70 million of which was specifically allocated to the Office of Inspector General. The remaining $34 million was divided between Justice, which received $24 million, and other HHS agencies, including HCFA, which received $1.8 million of these funds.

[14] High-Risk Series: Medicare (GAO/HR-97-10, Feb. 1997).

According to HHS Inspector General officials, the Office of Inspector General will use its $70 million to, among other things, hire 250 additional investigators, auditors, lawyers, and other analysts to pursue fraudulent providers. The Office of Inspector General recently published its plan for continuing Operation Restore Trust, an initiative begun in 1995 in response to the rapid growth in Medicare's spending for home health and nursing home services and medical equipment and supplies. This effort, conducted jointly by HHS and the Department of Justice, operated in five states and reported identifying almost $188 million in inappropriate payments in its 2 years of operation. In expanding Operation Restore Trust, the Inspector General has opened new investigative offices in six states this fiscal year. Officials also told us that, depending on its final budget, the office is planning to add another eight offices in fiscal year 1998.

According to Department of Justice officials, Justice will use its $24 million to hire 120 new prosecutors who will devote their work exclusively to prosecuting health care fraud. Ninety of the new prosecutors will join U.S. Attorneys' Offices nationwide. The remaining 30 will serve in Justice's Civil and Criminal Divisions in Washington, D.C. The Department also intends to hire additional support staff, including paralegals, auditors, and other analysts.

HIPAA also mandates the creation of a national data collection system reporting final adverse actions against health care providers. The system is intended to enable greater information-sharing among federal and state government agencies and health plans. According to Inspector General officials, the system is not likely to be fully operational for at least another 2 years.

Pending Legislation

Earlier we cited provisions in the pending budget reconciliation bill that address concerns about Medicare's payments for home health services. In addition, the legislation contains various other provisions directed at Medicare fraud and abuse. Among these are the following:

- A requirement to implement consolidated billing for nursing facility stays not covered by the new prospective payment system. Under such an arrangement, the nursing facility would have a greater incentive to monitor the care provided and the charges claimed by outside providers and suppliers. In past reports, we have also suggested consolidated billing for ancillary services provided in skilled nursing facilities.[15]

[15] Fraud and Abuse: Providers Target Medicare Patients in Nursing Facilities (GAO/HEHS-96-18, Jan. 24, 1996).

- Authority to refuse to enter into Medicare agreements with individuals or entities convicted of felonies. This gives the Inspector General the opportunity to prevent convicted felons from becoming Medicare providers.
- Requirement for providers to furnish key identification numbers. Medicare providers must furnish HHS with the Social Security and employer identification numbers for themselves and their owners, individuals with a controlling interest, and subcontractors in which the provider has an ownership interest. As we discussed in our March 1997 report on Medicaid providers, this would allow HCFA to trace problem providers through related health care organizations and better ensure that excluded individuals are not paid by the program.[16]

Legislative Activity Related to Medicare Managed Care

A recent legislative proposal, cosponsored by you, Madam Chairman, would help make information about beneficiary satisfaction with Medicare managed care plans publicly available. Among other things, the bill, S. 302, would require Medicare HMOs to conduct consumer satisfaction surveys. It would also authorize grants to states and other organizations to disseminate information comparing benefits, quality and performance, cost information, and the results of the satisfaction surveys of Medicare managed care plans.

Also, HIPAA gives HCFA more flexible sanction authority while providing HMOs the statutory right to greater procedural safeguards. In addition to existing authority to terminate an HMO's contract if the HMO did not meet requirements, HCFA now has the option of imposing lesser sanctions, such as suspending the HMO's right to enroll Medicare beneficiaries until the deficiencies are corrected.

Conclusions

Many of Medicare's vulnerabilities are inherent in its size and mission, making it a perpetually attractive target for exploitation. That wrongdoers continue to find ways to dodge safeguards illustrates the dynamic nature of fraud and abuse and the need for constant vigilance and increasingly sophisticated ways to protect against gaming the system. Judicious changes in Medicare's day-to-day operations involving HCFA's improved oversight and leadership, the mitigation of MTS acquisition risks, and HCFA's appropriate application of new anti-fraud-and-abuse funds are necessary ingredients to reduce substantial future losses. Moreover, as Medicare's

[16]Medicaid Fraud and Abuse: Stronger Action Needed to Remove Excluded Providers From Federal Health Programs (GAO/HEHS-97-63, Mar. 31, 1997).

managed care enrollment grows, HCFA must enhance its efforts to see that beneficiaries receive sufficient information about HMOs to make informed choices, and that the agency's authority to enforce HMO compliance with federal standards is used. To adequately safeguard the Medicare program, HCFA needs to meet these important challenges promptly.

How HCFA will use the funding and authority provided under HIPAA to improve its vigilance over Medicare benefit dollars has not yet been determined. The outcome is largely dependent on how promptly and effectively HCFA implements the act's provisions. As we have highlighted today, weak monitoring, poor coordination, and delays have characterized HCFA's past efforts to oversee fee-for-service contractors, the MTS acquisition process, and Medicare managed care plans. Thus, even with the promise of HIPAA and the potential enactment of additional legislation, the prospects for HCFA's success in combating Medicare fraud and abuse remain uncertain.

Madam Chairman and Members of the Subcommittee, this concludes my prepared remarks. I will be happy to answer any questions.

Appendix

Additional Data on Medicare Spending and Program Activities

Figure I.1: Claims Reviews Have Not Matched the Growth in Medicare Claims

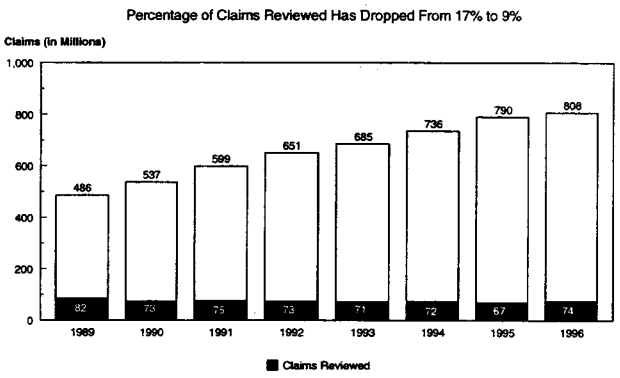


Figure I.2: Rising Costs of Medicare Home Health Benefit

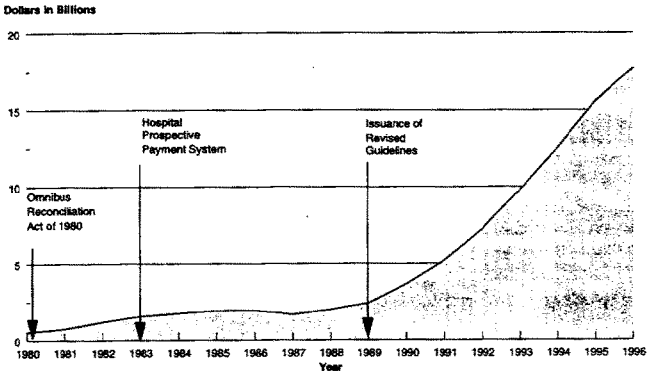
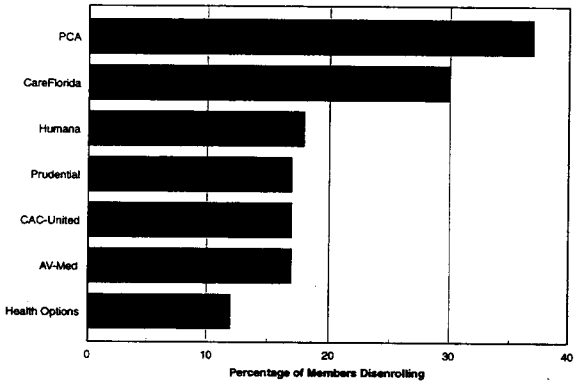


Figure I.3: Many Contractors Do Not Screen Claims for Costly Services

Based on a Review of 17 Contractors in 1994

Procedures	Medicare payments (in millions)	Contractors that have screens for the listed medical procedures (percentage)
Echocardiography	$851	41%
Eye exams	$686	35%
Chest x-rays	$507	35%
Colonoscopy	$478	35%
YAG laser surgery	$325	18%
Duplex scan of extracranial arteries	$143	47%

Figure I.4: Annual Disenrollment in Medicare HMOs in Miami, 1995



HEALTH CARE FRAUD

WRITTEN STATEMENT*

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Seventeen years ago I was introduced to health care fraud. As a new Assistant United States Attorney, I was assigned as the second chair to a health care fraud prosecution which had been indicted the day I started in the Office of the U. S. Attorney, for the Eastern District of Missouri. For the next seven years I prosecuted primarily white collar crime, always with a heavy dose of health care fraud. In 1986, at the request of United States Attorney Thomas E. Dittmeier, I established and served as coordinator of an interagency task force on health care fraud for the Eastern District of Missouri. Since leaving the Department of Justice in 1987 and becoming a law school professor, I have devoted my scholarly attention to health care fraud. I have also written, spoken and consulted in the area of health care fraud. From these experiences, I offer the following observations.

I. CHANGES IN HEALTH CARE FRAUD OVER THE PAST FIFTEEN YEARS

A. Health care fraud has become a larger problem.

Although there has been and always will be fraud in any endeavor where there is money, the amount of fraud being committed in health care has increased. I see four major reasons for this. First, the amount of money involved in health care has grown considerably. In 1980, national health expenditures were $251 billion; by 1995, they had quadrupled to $1,008 billion.[1] As Willie Sutton said when asked why he robbed a bank, "That is where the money is."[2]

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*Portions of this written statement are from PAMELA H. BUCY, HEALTH CARE FRAUD: CRIMINAL, CIVIL AND ADMINISTRATIVE LAW (LJSP 1996); Pamela H. Bucy, *Crimes By Health Care Providers* 1996 ILL.L.REV. 589 (1996); Pamela H. Bucy, *Civil Prosecution of Health Care Fraud*, 30 WAKE FOREST L.REV. 693 (1995); Pamela H. Bucy, *The Poor Fit of Traditional Evidentiary Doctrine and Sophisticated Crime: An Empirical Analysis of Health Care Fraud Prosecutions*, 63 FORDHAM L.REV. 383 (1994); Pamela H. Bucy, *Health Care Reform and Fraud by Health Care Providers*, 38 VILL.L.REV. 1003 (1994); Pamela H. Bucy, *Corporate Ethos: A Standard for Imposing Corporate Criminal Liability*, 75 MINN.L.REV. 1095 (1991); Pamela H. Bucy, *Fraud By Fright: White Collar Crime By Health Care Providers*, 67 N.C.L.REV. 855 (1989).

[1]PROSPECTIVE PAYMENT ASSESSMENT COMMISSION, REPORT AND RECOMMENDATIONS TO THE CONGRESS, 12 (Mar. 1, 1996).

[2]Quoted by Inspector General June Gibbs Brown, Department of Health and Human Services, ABA National Institute on Health Care Fraud, April 21, 1995, Miami, Florida.

Second, with the exception of a few providers such as physicians, it is fairly easy to enter the health care system as a provider. Any individual or business which wishes to establish itself as a home health care operator or a durable medical equipment supplier, for example, may do so. Credentialing for these types of providers is nonexistent or minimal. In a 1990 report, the GAO noted:

> "[S]tates have been slow to license freestanding providers. In fact states do not license or otherwise regulate most of the 16 types of freestanding providers.... For those freestanding providers that are licensed, however, states have imposed few sanctions for deficiencies identified during inspection."[3]

Weak credentialing makes it easier for scam artists to enter the industry, commit fraud and move on. It also makes it easier for legitimate businesses to get in over their heads through inadequate capitalization, training, or preparation; this causes some to resort to fraud. Minimal entry requirements also make it easier for organized crime to enter health care, which apparently it has done.[4] As FBI Director Louis J. Freeh has noted repeatedly, "organized crime ... has penetrated virtually every legitimate segment of the health care industry."[5]

A third reason for the large increase in health care fraud is that the industry is in flux, socially and economically. Currently there are too many providers, especially too many hospitals and specialist physicians. The rapid growth in health care since 1965 has left a bloated system. Between 1970 and 1991, for example, the number of medical physicians increased by 89.6%, the number of osteopathic physicians increased by 129.9%, the number of podiatrist increased by 76%, and the number of registered nurses increased by 134.5%.[6]

Although the number of health care professionals has increased, the pool of money to pay these professionals is destined to decrease even as the health care needs of baby boomers increase. Cost containment will shrink the affluent health care system to which we are accustom. Cost containment is also causing providers to band together, willingly or unwillingly. More health care providers than ever operate in the corporate form. Younger physicians are more willing to work for a corporate health care provider. Whereas almost all physicians with more than 30 years experience

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[3]GAO, LIMITED STATE EFFORTS TO ASSURE QUALITY OF CARE OUTSIDE HOSPITALS 2 (1990).

[4]Selwyn Raab, *Officials Say Mob is Shifting Crimes to New Industries*, N. Y. TIMES, A1, A10 (Feb. 10, 1997).

[5]*Testimony before Senate Special Committee on Aging*, March 21, 1995.

[6]Calculated from U. S. DEPT. OF HEALTH AND HUMAN SERVICES, FACT BOOK: HEALTH PERSONNEL UNITED STATES Table 101 (1993).

are self-employed, this is true for only 60% of those in practice five years or less.[7] As a result, national health care corporations are sprouting up and purchasing hospitals and nursing homes, which traditionally have been owned by small groups of individuals. The managers and administrators of these corporations are a new cadre of health care professionals who are shifting the focus in health care from service to profitability. With these changes, medicine is becoming more of a business than a profession. Fraud will flourish in such an environment.

The last major reason for the increase in fraud is that the health care industry is structured in a way that makes fraud easy to commit and hard to detect. The large number of insurers (both public and private), the volume of claims submitted, the numerous and often inconsistent billing requirements which apply to providers, and the lack of viable systems for detecting billing abuse all contribute to an atmosphere conducive for fraud.

Commendably, recent law enforcement efforts have been directed at systemic changes in the health care reimbursement system which will make it more difficult for unscrupulous providers to cheat. These include requiring all Medicare providers to have a National Provider Identifier which will help track providers through the system; creating a data base of problematic providers available to law enforcement and private insurers; consolidating the processing of claims for durable medical equipment by 30 local carriers to four regional carriers; encouraging greater cooperation among law enforcement agencies and with private insurers; and including new civil monetary penalties for physicians who falsify a patient's eligibility for home health services . As I discuss in Part II of this Written Statement, despite these commendable efforts, more steps should be taken to combat health care fraud.

B. The types of health care fraud being committed are changing as the American health care system moves toward a managed care reimbursement system which relies on capitation payments.

In 1960, health care costs consumed 5.3% of the gross national product (GNP) in the United States.[8] By 1995, health care costs consumed almost 14% of the GNP.[9] By the year 2,000 it is expected that health care costs will consume 18% of the GNP.[10] Businesses which pay for their employees' health coverage are devoting larger shares of their operating expenses to health care. In

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[7]L. HARRIS & ASSOCIATES, MEDICAL PRACTICE IN THE 1980'S: PHYSICIANS LOOK AT THEIR CHANGING PROFESSION 21 (1981). Goldsmith, The *U. S. Health Care system in the Year 2000*, 256 J.A.M.A. 3371, 3372 (Mar. 1, 1995).

[8]PROSPECTIVE PAYMENT ASSESSMENT COMMISSION, REPORT AND RECOMMENDATIONS TO THE CONGRESS, 15 (Mar. 1, 1993).

[9]*Id.* at 14.

[10]*Id.* at 15.

1965, business was spending 2.0% of total employee compensation on health care. In 1990, this share had risen to 7.1%.[11] Local, state and federal governments find it increasingly difficult to pay for health care for their employees and for those on Medicare and Medicaid.[12] The total cost of health care is estimated at 11.7 % of household income.

In response to the above facts, considerable attention has been devoted in recent years to curbing the growth of health care expenditures. Some of these efforts retain traditional fee for service reimbursement, while making efforts to control fees through caps, pre-authorization requirements, or higher copayments and deductibles. Another approach is "capitation" payment, whereby the provider is paid a set amount to care for a patient for a given period of time, such as one hospitalization, or one calendar year. The most significant change in capitation from fee for service is that capitation shifts the financial risk from the payer of the services to the provider of the services. This shift affects the types of fraud committed.

The way you pay people affects the way they cheat. Health care fraud epitomizes this. As the methods of health care reimbursement have changed, so have the types of fraud committed by unscrupulous health care providers. Under fee for service reimbursement, for example, billing for services not performed, and providing unnecessary services were lucrative forms of fraud. Under capitation methods of reimbursement, however, these frauds make no sense—the provider conducting them would lose money. Instead, under capitation reimbursement, frauds such as enrolling fictitious employees and failing to provide necessary medical services become lucrative. This section addresses the economic incentives for health care fraud, forecasting the fraud likely to occur under evolving reimbursement methods such as capitation and managed care.

1. Fee for Service Reimbursement. Fee for service reimbursement has dominated most of American twentieth century medicine.[13] From an anti-fraud perspective, it is a disaster. Fee for service, which pays per service rendered, encourages overutilization.[14] Under it, "the more

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[11]*Id.* 16.

[12]*Id.*

[13]Bucy, *Fraud by Fright: White Collar Crime By Health Care Providers*, 67 N.C.L. REV. 855, 861-69 (1989).

[14]Pontell et al, *Practitioner Fraud and Abuse in Medical Benefit Programs*, 6 LAW & POL'Y 405, 418 (1984). James C. Robinson, a health care economist at the University of California, Berkeley, offered the following analogy in explaining how fee for service insurance system feeds health care appetite: "Imagine if we sold auto-purchase insurance and said, go and buy whatever car you want and we'll pay 80 percent of it. Under those conditions, a lot of people would go buy a Mercedes." *Wasted Health Care Dollars*, 57 CONSUMER REPORTS 435 (1992).

doctors do, the more they get paid."[15] To the fraudulent provider, fee for service reimbursement also encourages the following types of fraud: (1) billing for services not provided; (2) billing for a more expensive service than what was actually provided; (3) providing and billing for unnecessary services while representing that the services were necessary; and, (4) paying kickbacks for referrals, including self-referrals.[16]

Reported cases exemplify each of these types of fraud. The first two types of fraud, billing for services not rendered and misrepresenting the type of service actually rendered, are easiest for the fraudulent provider to accomplish when the services legitimately occur in high volume, are difficult to verify by subsequent physical exam, and are administered to patients incapable of accurately recalling their treatment. Examples of such services are doctors visits,[17] disbursements of medicines,[18] and simple procedures such as x-rays.[19]

Misrepresentations regarding services rendered fall into two types, each type highlighting a different aspect of the fee for service reimbursement mechanism. One type of misrepresentation reflects the fact that insurers pay fees for some, but not all, services. In this type of fraud, the services actually performed by the provider were not compensable under pertinent payment guidelines yet the fraudulent provider misrepresented the service as compensable.

The second type of misrepresentation regarding services actually provided reflects the fact that insurers compensate more for some services than for others. Providers committing this type of fraud actually performed a compensable service but claimed they performed another, more highly compensable, service. Examples include: a medical laboratory that billed for "manual" blood tests

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[15]"Wasted Health Care Dollars," *supra* note 16, at 438 (quoting Dr. Philip Caper, M.D., health care policy analyst at Dartmouth Medical School).

[16]*See generally Fraud by Fright*, *supra* note 15, at 933.

[17]*See, e.g.*, United States v. Hilliard, 752 F.2d 578, 579 (11th Cir. 1985); United States v. Mitlo, 714 F.2d 294, 295 (3rd Cir.) *cert. denied*, 464 U.S. 1018 (1983).

[18]*See, e.g.*, United States v. Sanders, 749 F.2d 195, 197 (5th Cir. 1984); United States v. Ziperstein, 601 F.2d 281, 285 (7th Cir. 1979) *cert. denied*, 444 U.S. 1031 (1980).

[19]People v. American Medical Ctrs., 118 Mich. App. 135, 324 N.W.2d 782, 787 (Mich. App. 1982) *cert. denied*, 464 U.S. 1009 (1983). The procedure at issue in this case was anything but simple. Here, the defendant-physicians were convicted for billing Medicaid for "direct laryngoscopies" that had never been performed. *Id.* at 787. A direct laryngoscopy is an examination of the exterior and the interior of the larynx using an instrument that is inserted down a patient's throat. TABER, TABER'S CYCLOPEDIC MEDICAL DICTIONARY 931 (15th ed. 1985). The patients testified that they did not undergo this procedure. *American Medical Ctrs.*, 324 N.W.2d at 791.

when "automated" blood tests were performed;[20] a physician who billed for single-patient visits when the visits were with multiple patients;[21] a psychiatrist who misrepresented the length of psychiatric evaluations;[22] and, a nursing home that misrepresented the level of care given to patients.[23]

Billing for unnecessary services, the third type of fraud encouraged by the fee for service payment system, is not, by itself, a fraud. It becomes fraud when a claim for reimbursement carries the false representation that the service was necessary. Because the fee for service system rewards the rendering a high volume of services, there is strong incentive for the fraudulent provider to perform and bill for unnecessary services. Although difficult to prove as fraud, as opposed to simple malpractice, this type of fraud gives plaintiffs a major advantage by clearly identifying the patient, who suffered the unnecessary medical procedures, as a victim of the provider's malfeasance. Most health care fraud prosecutions identify an insurance company or the government as the victim of the fraud because it lost, or could have lost, money due to the defendant's dishonesty. Insurance companies and governmental agencies, are not sympathetic victims in the eyes of most people. By contrast, patients who have received inadequate, incompetent, or unnecessary medical services are genuinely sympathetic victims and tend to make a plaintiff's case much stronger.

The incentive for the last type of fraud encouraged by fee for service reimbursement, paying kickbacks for referrals, also derives directly from the emphasis on volume in fee for service reimbursement. Kickbacks are one way for the unscrupulous provider to increase volume. In a fee for service system, the kickbacks routinely flow from one provider to another and are easily concealed in legitimate payments simultaneously flowing between the providers.[24] Reported cases exemplify these types of kickbacks: fees paid by medical laboratories to physicians to induce referrals of patient specimens;[25] payments by durable medical equipment companies to hospital or nursing home personnel by durable medical equipment companies to induce the purchase of

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[20]United States v. Precision Medical Lab., Inc., 593 F.2d 434, 438 (2d Cir. 1978).

[21]People v. Lee, 134 Mich. App. 278, 351 N.W.2d 294, 297 (Mich. App. 1984).

[22]State v. Dean, 105 Wis.2d 390, 314 N.W.2d 151, 154 (Wis. Ct. App. 1981).

[23]United States v. Huckaby, 698 F.2d 915, 916 (8th Cir. 1982) *cert. denied*, 460 U.S. 1070 (1983).

[24]Bucy, *Fraud by Fright*, *supra* note 15 at 914-20.

[25]United States v. Lipkis, 770 F.2d 1447, 1449 (9th Cir. 1985); United States v. Sadlier, 649 F. Supp. 1560, 1561 (D. Mass. 1986).

equipment and supplies;[26] and, payments to city officials to induce referral of ambulance business.[27]

Kickbacks also may be in the form of self-referrals, for example, where an internist owns the laboratory to which she refers specimens of her patients. Considerable attention has focused on this problem recently, with the promulgation of regulations that provide a "safe harbor" to some self-referral arrangements.[28]

Unfortunately, each of the four types of fraud that flourish in the fee for service system are easy to commit and difficult to detect. Billing for services not rendered and misrepresenting the nature of services actually provided are the easiest of the frauds to commit and the most difficult to detect because the actual rendering of services takes place in the privacy of the provider-patient relationship. When these services legitimately occur in large volume, leave no physical manifestations when actually performed, and are performed on patients unable to recall the rendering of services, they become almost impossible to detect or prove. Providing and billing for unnecessary services is difficult to prove because of the subjective nature of medicine. What one provider deems to be unnecessary, another believes to be essential. Proof of intentional fraud becomes difficult in all but the most egregious cases. Kickbacks for referrals are difficult to detect because they occur between a small number of close knit professionals and are easily laundered in legitimate payments.

Requiring pre-authorization before services are rendered is one way to try to limit the fraud and abuse inherent in fee for service. This tactic has been widely adopted. Ninety percent of workers in larger firms (100 or more employees), enrolled in fee-for-service plans, are required to obtain pre-authorization for certain services.[29] Such preauthorization should help overcome to propensity to overutilize and falsify services or the necessity for services. On the other hand, price controls such as caps on fees,[30] do nothing to discourage any of the types of fraud prevalent in fee for service systems because the fraudulent provider is still financially rewarded for increasing volume. The only way to discourage the volume-enhancing types of fraud is to decrease the fee amount when a certain volume—either in terms of the amount of services rendered or in income

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[26]*Sixth Circuit:* United States v. Perlstein, 632 F.2d 661, 662 (6th Cir. 1980) *cert. denied*, 449 U.S. 1084 (1981); United States v. Tapert, 625 F.2d 111, 115 (6th Cir.) *cert. denied*, 449 U.S. 1034 (1980).

[27]*First Circuit:* United States v. Bay Ambulance and Hospital Rental Serv., Inc., 874 F.2d 20, 23-26 (1st Cir. 1989).

[28]42 C.F.R. § 1001.952(a).

[29]PROSPECTIVE PAYMENT ASSESSMENT COMM'N, REPORT AND RECOMMENDATIONS TO THE CONGRESS, 15 (Mar. 1, 1995).

[30]Recent health care reform proposals included caps on health care fees. For example in 1992 caps went into effect for physicians' fees under Medicare. 42 U.S.C. § 1395w-4.

earned by a provider—is reached.[31] The problem with this step is that it is arbitrary and could lead to poor quality of health care. Also, it does not discourage fraud until a set volume is reached.

2. Capitation Reimbursement. Capitation reimbursement pays a provider a set amount of money for all services rendered by the provider to a "covered" person in a given period of time, usually one year.[32] The "DRGs" (diagnostic related category) implemented by Medicare[33] are one example of capitation payment. Beginning in 1982, Part A Medicare providers are reimbursed a set amount depending on the diagnostic category of the patient's illness.[34] Under this reimbursement, illnesses are assigned to groups, based upon the "estimated relative cost of hospital resources used with respect to discharges classified within each group."[35] The Health Care Financing Administration (HCFA) of the Department of Health and Human Services (HHS) has defined 467 different diagnostic categories and established a formula for reimbursing per category.

Whereas fee-for-service operates retrospectively, by reimbursing a provider after it has rendered the service, the DRGs constitute a prospective payment system (PPS) that informs the provider of the reimbursement for the service prior to the rendering of the service. The incentive to

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[31]Incentives to decrease volume exist in parts of Canada. See Clyde H. Farnsworth, *Now Patients Are Paying Amid Canadian Cutbacks*, N.Y. TIMES, Mar. 7, 1993, at A1, A10. For instance, in Ontario, physicians whose total billings reflect more than 20% house calls receive only $41.50 per house call exceeding 20% instead of the $71 per house call that the physician would otherwise receive. *Id.* In addition, fees drop for physicians earning more than $400,000 per year (five percent of Ontario's physicians). *Id.*

[32]With capitation reimbursement, medical care would be managed to "include such practices as restricting patients to a single primary-care doctor who must approve all specialist referrals; penalizing doctors who order too many tests or procedures; and, pre-approving elective hospitalization." "Wasted Health Care Dollars," *supra* note 16, at 435; *See also* PAUL STARR, LOGIC OF REFORM 40-42 (1992).

This definition differs slightly from Starr's definition of managed care as embracing "any health plan that limits the choice of providers or regulates their treatment decisions to eliminate inappropriate care and reduce costs." Starr, *Logic of Reform*, *supra*, at 40. Starr notes that the original concept of managed care has been expanded with the inclusion of a variety of provider groups, some relying on traditional (fee for service) payment arrangements. *Id.* Thus, Starr concludes, "it is not possible to generalize about the overall record of managed care." *Id.*

[33]Social Security Amendments of 1983, Pub. L. No. 98-21, 97 Stat. 65, 77.

[34]"Hospital Prospective Payment System: Hearing Before the Subcomm. on Health of the Senate Comm. on Finance," 98th Cong., 1st Sess. 3, 6 (1983).

[35]42 C.F.R. § 412.60(b) (1987).

control costs is obvious: if the provider treats a patient for less than the amount it receives as reimbursement, it makes money, but if the provider treats the patient for more than the amount it receives as reimbursement; it loses money.[36] It appears that DRGs are effective in controlling health care costs, and other third-party insurers have instituted similar prospective payment systems.[37]

Health Maintenance Organizations (HMOs) are another example of capitation plan. An HMO is paid a set amount of money for providing a member with all health services necessary during a set time period, usually one year.[38] If the HMO treats the member for less than the amount, it makes money; if it does not, it loses money.[39] Because HMOs take years to develop and require major infusions of capital, the Health Maintenance Organization Resources Act of 1973[40] was passed, and has been amended, to facilitate the growth the HMOs. This statute provides financial assistance to developing HMO's[41] and requires employers to offer an HMO option as one of its health care benefits. After a slow start, the number of HMOs has grown dramatically. In 1985 about 8% of the U.S. population was enrolled in HMOs. By 1994, this had more than doubled to 20%.[42] In 1988, 29% of employees covered by health insurance were enrolled in managed care plans. By 1995, this percentage had jumped to 70%!

Currently, the distribution of persons enrolled in HMOs is very uneven. Almost 35% of residents in California and Massachusetts are enrolled in HMOs whereas in West Virginia an Wyoming there is "virtually no HMO activity."[43] Medicaid recipients are rapidly becoming members of HMOs. Between 1993 and 1994 the number of Medicaid recipients in HMOs increased by 66%, from 4.8 million to 8 million. By 1994, almost 24% of the Medicaid population was enrolled in

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[36]*Proposals to Modify Medicare's Physician Payment System: Hearing Before the Subcomm. on Health of the Senate Comm. on Finance*, 99th Cong., 2nd Sess. 9 (1986).

[37]PROSPECTIVE PAYMENT ASSESSMENT COMM'N, MEDICARE PROSPECTIVE PAYMENT AND THE AMERICAN HEALTH CARE SYSTEM 86 (1987).

[38]Furrow, *The Ethics of Cost Containment*, 3 NOTRE DAME J.L. ETHICS AND PUB. POL'Y 190 (1988).

[39]GAO, MEDICARE--ISSUES RAISED BY FLORIDA HEALTH MAINTENANCE ORGANIZATION DEMONSTRATIONS, 99th Cong., 1st Sess. 44 (1986).

[40]Federal Health Maintenance Organization Act of 1973, Pub. L. No. 93-222, 87 Stat. 914 (codified at 42 U.S.C. § 300e (1982)).

[41]42 C.F.R. §§ 417.110-.137.

[42]PROSPECTIVE PAYMENT ASSESSMENT COMM'N, REPORT AND RECOMMENDATIONS TO THE CONGRESS, 15 (Mar. 1, 1995).

[43]*Id.*

HMOs.[44]

Capitation payments shift the financial risk from that found in a fee for service reimbursement system. With fee for service reimbursement, the entity paying the fees bears the risk. This usually has been the employer, who has paid for the health care services received by employees. Or, with government programs such as Medicare and Medicaid, it has been the government which assumed the financial risk. In contrast, with capitation payment, the provider which is paid the set rate to provide all agreed upon services, bears the risk. If it provides more services than money it receives, the provider loses money, if it provides fewer services than payment, it makes money.

Because of this shift in financial risk, the economic incentives for fraud in a capitation system are different than those in a fee for service system. With capitation payment, the unscrupulous provider has the financial incentive to submit false cost data to obtain a higher capitation rate; register fictitious enrollees; fail to provide necessary services; and, pay kickbacks for referrals of *certain* patients—healthy patients.[45] In a capitation system, there is no incentive to overutilize services and thus no incentive for the types of fraud that flourish in a fee for service system.

a. False Cost Data. Capitation payment encourages unscrupulous providers to submit false cost data to obtain a higher capitation reimbursement rate. Periodically, in a capitation system the reimbursement rate will be renegotiated to account for changes in cost. Providers submit much of this cost data. Unfortunately, false cost reporting is among the most difficult types of health care fraud to detect and prove.[46] For example, it is difficult to prove that a cost report actually includes inflated costs or improper expenses. Generally, isolating suspect entries in a cost report is an accounting issue. The accountant preparing the cost report is needed to demonstrate how specific costs and expenses are recorded and carried forward to the cost report.[47] If the books, records, or testimony necessary to show this are unavailable, it will not be possible to prove the falsity of a cost report.

Another problem in proving submission of a false cost report is demonstrating that any particular person knew that the report was false. The actual preparer of the report may credibly claim

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[44]*Id.*

[45]*Cf.* Pontell, *Practitioner Fraud and Abuse*, *supra* note 16, at 418-20 (Suggesting that regardless of payment structure of government medical programs, creation of strict norms for determining necessity and adequacy of health care rendered is necessary to successfully detect and prove health care fraud).

[46]Bucy, *Fraud by Fright*, *supra* note 15, at 908-14.

[47]But see United States v. Cella, 568 F.2d 1266, 1272 (9th Cir. 1977) (controller of hospital testified to accounting entries resulting from instructions given to him by defendant-officer of hospital).

ignorance, legitimately or not, because she received cost information from others. The supplier of the actual cost information, assuming that person can even be identified within a large organization, can also credibly claim ignorance, incompetence, or good faith error on the grounds that he was not involved in the actual cost report preparation. Such claims of ignorance are credible because of the many people usually involved in preparing a cost report, complex regulations applicable to cost reporting, and the expertise and specialization needed by cost report preparers.

Reported cases reveal how a plaintiff, in a civil or criminal proceeding, may prove that a defendant knew that the improper expense was inaccurately listed in a cost report. In *United States v. Smith*,[48] for example, the United States Court of Appeals for the Fifth Circuit addressed this knowledge issue and discussed what evidence would suffice to prove it:

> It is not necessary that [the defendant] have known which line was incorrect when he approved the [cost report] forms, nor that he be able to properly fill out the forms himself.... It suffices that he understood the forms necessarily to include expenses which were not those of the hospital, and that a percentage of the amount claimed would be reimbursed erroneously to the hospital from [the United States Department of Health, Education and Welfare].[49]

A defendant's knowledge may be shown circumstantially. For example, knowledge has been shown with evidence that a defendant knew the general method by which the Medicare reimbursement program worked;[50] that a defendant approved all checks for the improper expenses;[51] that a defendant

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[48]523 F.2d 771, 780 (5th Cir. 1975) *cert. denied*, 429 U.S. 817 (1976).

[49]*Id.*

[50]*See, e.g.*,

Second Circuit: United States v. Huber, 603 F.2d 387, 398 (2d Cir. 1979) (affirming defendant's fraud conviction based on evidence defendant was familiar with mechanics of government funding programs), *cert. denied*, 445 U.S. 927 (1980);

Fifth Circuit: United States v. Smith 523 F.2d 771, 774 (5th Cir. 1975) *cert. denied*, 429 U.S. 817 (1976) (affirming defendant's fraud conviction based on testimony that established defendant knew general method of Medicare reimbursement program);

State Courts:

Massachusetts: Commonwealth v. Minkin, 14 Mass. App. Ct. 911, 436 N.E.2d 955, 958 (Mass. App. Ct. 1982) (noting defendant's experience and familiarity with procedures for reimbursement from Medicaid as factor in affirming fraud conviction).

[51]*See, e.g.*, *Smith*, 523 F.2d at 775 (upholding fraud conviction where defendant retained complete financial control of hospital and evidence showed hospital money was used to remodel defendant's home).

accepted delivery and endorsed checks for improper expenses;[52] that a defendant's exculpatory explanations were contradicted by the facts;[53] and with evidence that the defendant failed to supply his accountant with accurate information or instructions.[54]

Especially with criminal cases, it can be difficult to properly plead a cost reporting offense. Historically, a number of criminal statutes have been used to charge false cost reporting. In the federal system, the following offenses have been used: false statements,[55] mail fraud,[56] conspiracy,[57]

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[52]*See, e.g.*, United States v. Jones, 587 F.2d 802, 804 (5th Cir. 1979) (affirming defendant's fraud conviction based on evidence that defendant accepted reimbursements for travel when in fact no travel had been conducted).

[53]*See, e.g.*, *Smith*, 523 F.2d at 774 (rejecting defendant's claim that simple bookkeeping mistakes were made when evidence showed hospital money was used to remodel defendant's home).

[54]*See, e.g.*,

Ninth Circuit: United States v. Cella, 568 F.2d 1266, 1272 (9th Cir. 1977) (affirming fraud conviction where defendant solicited payment for undocumented expenses from hospital controller);

State Courts:

Massachusetts: Commonwealth v. Minkin, 14 Mass. App. Ct. 911, 436 N.E.2d 955, 958 (Mass. App. Ct. 1982) (affirming fraud conviction where evidence showed defendant failed to instruct accountant to segregate, in cost reports, personal expenses from hospital expenses).

[55]18 U.S.C. § 1001 (1976). The statute provides:

> Whoever...knowingly and willfully falsifies, conceals or covers up by any trick, scheme, or device a material fact or makes any false, fictitious or fraudulent statements or representations, or makes or uses any false writing or document knowing the same to contain any false, fictitious or fraudulent statement or entry, shall be fined not more than $10,0000 or imprisoned not more than five years or both.

[56]18 U.S.C. § 1341 (1984). The statute provides:

> Whoever, having devised or intending to devise any scheme or artifice to defraud or for obtaining money or property by means of false or fraudulent pretenses...places in any post office or authorized depository for mail matter...shall be fined not more than $1,000 or imprisoned not more than five years or both. If the violation affects a financial institution, such person shall be fined not more than $1,000,000 or imprisoned not more than 30 years, or both.

[57]18 U.S.C. § 371 (1966). The statute provides, in relevant part:

> If two or more persons conspire either to commit any offense against the United States, or to defraud the United States, or any agency thereof in any manner or for any purpose, and one or more of such persons do any act to effect the object of the conspiracy, each shall be fined not more than $10,000 or imprisoned not more

transporting in interstate commerce money obtained by fraud,[58] RICO,[59] theft of government property,[60] tax evasion,[61] and filing false tax returns and aiding and abetting in their preparation.[62]

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than five years, or both....

[58]18 U.S.C. § 2314 (1970 & Supp. 1993). The statute provides, in relevant part:

Whoever, having devised or intending to devise any scheme or artifice to defraud, or for obtaining money or property by means of false or fraudulent pretenses, representations, or promises, transports or causes to be transported, or induces any person or persons to travel in, or be transported in interstate or foreign commerce in the execution or concealment of a scheme or artifice to defraud that person or those persons of money or property having a value of $5,0000 or more. ...

Shall be fined not more than $10,000 or imprisoned not more than ten years or both.

[59]18 U.S.C. §§ 1961-1963 (1984 & Supp. 1992) (prohibiting racketeering or any benefit therefrom whereby racketeering includes, but is not limited to mail fraud and interstate transportation of stolen property).

[60]18 U.S.C. § 641 (1976). The statute provides, in relevant part:

Whoever embezzles, steals, purloins, or knowingly converts to his use or the use of another, or without authority, sells, conveys or disposes of any record, voucher, money, or thing of value of the United States or of any department or agency thereof, or any property made or being made under contract for the United States or any department or agency thereof; or

Whoever receives, conceals, or retains the same with intent to convert it to his use or gain, knowing it to have been embezzled, stolen purloined or converted-

Shall be fined not more than $10,000 or imprisoned not more than ten years, or both; but if the value...does not exceed the sum of $100, he shall be fined not more than $1,000 or imprisoned not more than one year, or both.

[61]26 U.S.C. § 7201 (1989). The statute provides:

Any person who willfully attempts in any manner to evade or defeat any tax imposed by this title or the payment thereof shall, in addition to other penalties provided by law, be guilty of a felony and, upon conviction thereof, shall be fined not more than $100,000 ($500,000 in the case of a corporation), or imprisoned not more than 5 years or both, together with the costs of prosecution.

[62]26 U.S.C. § 7206(1)-(2) (1989). The statute provides, in relevant part:

(1) **Declaration under penalties of perjury**. —Willfully makes and subscribes any return, statement, or other document, which contains or is verified by a written declaration that it is made under the penalties of perjury, and which he does not believe to be true and correct as to every material matter; or

(2) **Aid or assistance**. —Willfully aids or assists in, or procures, counsels,

In state systems, the following offenses have been used: larceny or attempted larceny by false pretense,[63] Medicaid fraud,[64] theft,[65] conspiracy,[66] and falsifying business records have been used.[67] The new health care fraud offense (18 U.S.C. § 1347) created by the Health Insurance Portability and Accountability Act of 1996[68] should help alleviate this charging dilemma, at least in the federal courts.

Prosecution under any of the above federal and state statutes can present problems of multiplicity and duplicity. Multiplicity is charging a single offense in several counts. Duplicity is joining in a single count two or more offenses.[69] A multiplicatus indictment may be dismissed

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> or advises the preparation or presentation under, or in connection with any matter arising under, the internal revenue laws, of a return, affidavit, claim, or other document, which is fraudulent or is false as to any material matter, whether or not such falsity or fraud is with the knowledge or consent of the person authorized or required to present such return, affidavit, claim or document. ...

[63]*See, e.g.*,

State Courts:

Massachusetts: United States v. Minkin, 14 Mass. App. Ct. 911, 436 N.E.2d 955, 957 (Mass. App. Ct. 1982) (affirming defendant's convictions for attempted larceny by false pretense for submission of false reimbursement reports to Rate Setting Commission); Commonwealth v. Cerveny, 373 Mass. 345, 367 N.E.2d 802, 804 (Mass. 1977) (charging that annual reports of nursing home that were submitted by defendant to Rate Setting Commission contained material falsehoods);

New York: People v. Notey, 72 A.D.2d 279, 423 N.Y.S.2d 947, 948 (1980) (charging defendant submitted false claims to Medicaid resulting in lost between one and three million dollars).

[64]*See, e.g.*, Greco v. State, 307 Md. 470, 515 A.2d 220, 221 (Md. 1986) (charging defendant included non-reimbursable expenses in annual cost reports submitted to Medicaid).

[65]*Id.*, 515 A.2d at 220 (charging that defendant received non-reimbursable expenses due to falsifying annual cost reports submitted to Medicaid).

[66]*Notey*, 423 N.Y.S.2d at 948 (charging that defendant conspired with his two sons to submit false claims to Medicaid that resulted in defrauding Medicaid program between $1 and $3 million dollars).

[67]*Id.*

[68]HIPAA, Pub.L. 104-191, § 241.

[69]*See generally* United States v. UCO Oil Co., 546 F.2d 833, 835 (9th Cir. 1976) *cert. denied*, 430 U.S. 966 (1977) (holding admissibility problem particularly significant where conspiracy charged due to evidentiary rules about declarations by co-conspirators); 1 C. Wright, *Federal*

because it subjects a defendant to double jeopardy.[70] A duplicitous indictment may be dismissed because of the danger that the jury would "find a defendant guilty on a count without having reached a unanimous verdict on the commission of a particular offense."[71] Properly pleading cost report fraud becomes difficult when a single document contains multiple false statements.[72] Generally it is appropriate to plead each false statement as a separate count whenever different facts are needed to prove the falsity.[73]

Practice and Procedure § 142 (1982). Duplicity and multiplicity rules concern the fundamental due process rights of defendants. *Id.* Duplicity reflects the fear that a jury may find a defendant guilty where they may not have reached a verdict on commission of an actual offense. *Id.* This principle would conflict with substantive Sixth Amendment rights of the accused and possibly prejudice a double jeopardy defense. *Id.*

[70]*See generally* United States v. Conn, 716 F.2d 550, 552 (9th Cir. 1983) (holding that defendant cannot be charged with possession or receipt of several weapons received at same time and same place).

[71]*Ninth Circuit: UCO Oil Co.*, 546 F.2d at 835; see also United States v. Morse, 785 F.2d 771, 774 (9th Cir.) *cert. denied*, 476 U.S. 1186 (1986) (noting that duplicitous indictment precludes assurance of jury unanimity and may preclude subsequent double jeopardy defense); United States v. Aguilar, 756 F.2d 1418, 1422 (9th Cir. 1985) (noting that duplicity in indictment would constitute reversible error only if defendant was misled to his prejudice).

[72]U.S. DEPARTMENT OF JUSTICE, U.S. ATTORNEY'S MANUAL §§ 9-40.170, 9-42.220 to 42.221 (1984). The general rule is that as long as different facts are needed to prove each false statement, each false statement constitutes a separate count. *See, e.g.,* Blockburger v. United States, 284 U.S. 299, 304, 52 S.Ct. 180, 76 L.Ed. 306, (1932) (holding that "where the same act or transaction constitutes a violation of two distinct statutory provisions, the test to be applied to determine whether there are two offenses or only one, is whether each provision requires proof of a fact which the other does not"); United States v. Schrenzel, 462 F.2d 765, 771 (8th Cir.) *cert. denied*, 409 U.S. 984 (1972) (noting "the test to be applied to determine whether there are two offenses or only one is whether each count requires proof of an additional fact which the other does not").

[73]The Health Care Fraud Prevention Act of 1995, S.245 104th Cong., 1st Sess., introduced January 22, 1995, provides for a new criminal offense: Whoever knowingly executes or attempts to execute, a scheme or artifice to defraud any health plan or other person, in connection with the delivery of or payment for health care benefits, items, or services...." *Id.* at § 501. Violation of this offense carries a maximum prison sentence of 10 years, or if serious bodily injury results, for any term of imprisonment. *Id.*

See, e.g., "The Health Security Act," which proposes a new criminal statute aimed at health care fraud. H.R. 3600, S. 1757, 103d Cong., 1st Sess. § 5431 (1993) (the "Clinton" Plan). As drafted, this proposed statute would cover submission of false cost reports but does not clarify the

b. Registration of Fictitious Enrollees. The second type of fraud which capitation reimbursement encourages is registration of fictitious enrollees by providers. Because payments to providers are made per enrollee, there is incentive for unscrupulous providers to inflate the number of persons enrolled in a capitation plan. A recent case in Tennessee demonstrates this. The Tennessee Medicaid program has implemented managed care. Recently, one individual pled guilty to defrauding this program by enrolling 260 state prison inmates, whose health care was already covered by the prison system. Tennessee investigators also uncovered forged enrollments in another capitated plan on the part of 75 Saturn automobile dealers.[74] Registering of fictitious enrollees could be largely prevented through use of sufficient registration information and computer databases, both of which are increasingly available.

c. Failure to Provide Necessary Services. The third type of fraud encouraged by capitation reimbursement is the failure to provide necessary services.[75] This failure becomes fraud if reimbursement is obtained upon the false representation that all necessary services have been provided. Capitation payment makes under providing necessary services lucrative since by skimping on services provided, an unscrupulous provider is able to pocket some, or all, of the capitated amount it received for care of the patient.

There are several ways unscrupulous providers can avoid providing necessary services: enrolling members who are unsophisticated, locating health care offices in inconvenient places for enrollees, keeping the office open odd or only a few hours are some of the tactics unscrupulous providers may employ to avoid supplying necessary health care services.

Exercises of professional judgment which result in inadequate services, however, is almost impossible to prove as fraud.[76] A Maryland case demonstrates how egregious the poor quality of care must be before it can be treated as fraud, at least for criminal purposes. A Maryland physician was recently convicted on felony Medicaid fraud charges for failing to provide necessary care to Medicaid patients. The physician received a monthly fee for rendering a "comprehensive" medical examination for enrolled Medicaid patients. The evidence showed that the physician "treated" 90-100 patients per day, recorded identical blood pressure and pulse rate for each patient, and used a rubber stamp to record, in each patient file, an identical diagnosis. This physician was unable to

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multiplicity/duplicity problem. *Id.*

[74]"Health Care Fraud, Hearings before the Senate Select Comm. on Aging," 104th Cong., 1st Sess. at ____ (Mar. 21, 1995) (Prepared Remarks of William J. Mahon, Executive Director, NHCAA).

[75]PROSPECTIVE PAYMENT ASSESSMENT COMMISSION, REPORT AND RECOMMENDATIONS TO THE CONGRESS, 13 (Mar. 1, 1995).

[76]Bucy, *Fraud by Fright*, *supra* note 15, at 920-33.

recall a single patient's name when questioned.[77]

d. Corruption. The fourth type of fraud encouraged by capitation reimbursement is corruption. There will be incentive for corruption on two levels: (1) in organizing and monitoring the groups of providers, and (2) in enrolling patients with provider groups.

In a capitation system where groups of providers are paid to service all health care needs for enrollees, the groups will be large. Each group will include primary care givers, specialists, in- and out-patient facilities and therapists: physical, occupational and respiratory. Because of the incentive to under provide services, it will be important that these provider groups be monitored carefully for quality control. This trend to large provider groups operated as a business will dovetail with the social changes already noted: fewer total dollars going to health care, an overabundance of some types of providers, entry into the field of new types of unlicensed providers. Individuals charged with monitoring provider groups will have lucrative opportunities to extort and accept bribes for favorable decisions in qualifying, overseeing and disciplining these providers. The individuals establishing the provider groups will have incentives to seek bribes from individual providers who wish to affiliate with the group. All of this could lead to large scale corruption.[78]

There will also be economic incentives in a capitated system to pay kickbacks for enrolling certain patients in a capitated plan—*healthy* patients. As discussed, in a capitated system the provider which is paid more than it costs to render services to patients, makes money. Healthy patients need fewer services than do sick patients and make money for capitated plans. Kickbacks to individuals who have direct or indirect authority to enroll persons in capitation plans is one way to get healthy patients.

Kickbacks in a capitation system would not be as much of a problem as they are in a fee for service system, however. To understand why, it is necessary to examine the goals of, and parties to, kickbacks in both systems. In a fee for service system, the kickback typically flows from one provider to another for referrals of patients who need services, or at least for whom services can be billed. In such a system, where volume of services translates into money, kickbacks are paid to increase volume of services. Laboratories, diagnostic centers and hospitals paying physicians for

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[77]"Health Care Fraud, Hearing before the Senate Select Comm. on Aging," 104th Cong., 1st Sess., at ____ (Mar. 21, 1995) (Prepared statement of Thomas A. Temmerman, Director, California Bureau of Med-Cal Fraud.)

[78]Such corruption has not yet been seen in health care. To confront it will require new tactics and tools such as ensuring that contracts to provide health care be made as public as possible, that law enforcement have wire tapping and other authority to conduct corruption investigations and that statutes addressing corruption be clarified or amended for application in the health care area. "Health Care Fraud, Hearing before the Senate Select Comm. on Aging," 104th Cong., 1st Sess. ____ (Mar. 21, 1995) (Prepared statement of FBI Director, Louis J. Freeh).

admitting or referring specimens are classic examples of kickbacks in a fee for service system.[79]

In a capitation system, however, a kickback would be paid to encourage referrals of healthy patients who require few health care services but for whom the provider is paid the same amount as it is paid for ill patients. Also, in a capitation system, the kickbacks would not be between individual providers but between an administrator for a capitation plan and thousands of enrollees, or the individual(s) who make or influence enrollment decisions for others. These differences in the goals of, and parties to, the kickback mean two things: (1) in a capitation system, kickbacks will be more difficult to consummate than in a fee for service system; and, (2) in a capitation system, kickbacks will be difficult to hide. Both of these facts should help deter, or at least enhance the detection of kickbacks in a capitation system.

When a kickback is from one provider to another, as it is in a fee for service system, the kickback takes place between two, or at most a few, close knit professionals. In a capitation system, a kickback must flow from a provider (or a group of providers, probably represented in the kickback endeavor by one or a few persons) to thousands of individual consumers if individuals make their own enrollment decision. Payments to so many people are logistically difficult and virtually impossible to conceal. If the enrollment decision is made by a representative of individual consumers, then the kickback becomes somewhat easier to manage since the provider (or provider representative) need pay off only the representative of individual consumers. Nevertheless, even kickbacks to a consumer representative will be more difficult to conceal than are kickbacks in a fee for service system where the kickback can be hidden in legitimate payments already flowing between the providers. In a fee for service system, providers paying and receiving kickbacks have, or can arrange to have, legitimate business with each other. The physician who is paid a kickback by a clinical laboratory needs to refer the lab work on her patients somewhere. If she refers it to the lab paying her kickbacks, the kickbacks can be hidden in the financial transactions legitimately existing between her and laboratory.[80] By comparison, it would be extremely rare for a provider (or provider

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[79]*See, e.g.*, United States v. Lipkis, 770 F.2d 1447, 1449 (9th Cir. 1985) (involving laboratory kickback in exchange for referrals).

[80]Case law favors the prosecution, holding that the payment is an illegal remuneration even if it is in part reimbursement for legitimate services rendered, "if one purpose behind the fee was to improperly induce future services." United States v. Greber, 760 F.2d 68, 69 (3d Cir.) *cert. denied*, 474 U.S. 988 (1985). Nevertheless, the commingling of legitimate and illegitimate purposes for a payment make it difficult to prosecute these cases. See generally Frankford, *Creating and Dividing the Fruits of Collective Economic Activity: Referrals Among Health Care Providers*, 89 COLUM. L. REV. 1861, 1911 (1989) (discussing viability of containing costs of Medicare and Medicaid programs in which providers jointly care for patients); *cf.* United States v. Bay State Ambulance & Hosp. Rental Serv. Inc., 874 F.2d 20, 23-26 (1st Cir. 1989) (holding that defendant could be found guilty of conspiracy to commit Medicare fraud if only payments were primarily made for improper purpose); United States v. Kats, 871 F.2d 105, 108 (9th Cir. 1989) (holding as correct trial court's admonition that jury could not convict unless it found payment wholly and not incidentally

representative) and a consumers' representative in a capitation system to engage in independent, legitimate business dealings where they could conceal kickbacks. It would be unheard of for a provider (or provider representative) to have independent, legitimate business dealings, and thus a legitimate payment in which to launder the kickback, with thousands of enrollees.

Although a capitation system would make kickbacks more difficult to carry out, the following types of questions will need to be resolved before kickbacks are prohibited in a capitation system: is offering a standard benefit package at a lower cost than competitors a kickback?; is rebating a portion of a provider group's year end profits to enrolled members a kickback?; are "perks" that also constitute good preventive care, like free flu shots, nutritional counseling or athletic facilities, kickbacks?

e. "Kiting" Patients. A recent case in California demonstrates this type of fraud, which resembles check kiting in banks. A Medicaid patient would choose an HMO provider; California began paying the HMO its fee for covering the patient but the HMO did not tell the primary provider for 30 days that the patient was enrolled with the provider. If the patient needed to see the primary care provider during those thirty days, there was a "mix up." If the patient or provider was persistent, payment might be made after the fact; few were. If the patient did not need to see the primary care provider in the thirty days, no one was wiser and the HMO skimmed the 30 day payment. To enhance the skim, the HMO reassigned patients every 60 or 90 days (always with a 30 day "float"). One California Medicaid HMO had 24% of its patients unassigned at any one time.[81]

f. Marketing Fraud. Because HMOs with healthy patients make more money, some HMOs have resorted to aggressive, if not false, advertising to lure prize patients to HMOs. For example, in June, 1995, seventeen HMO recruiters, as well as the social workers who sold patient names and numbers to the recruiters, pled guilty to charges of fraud in recruiting medicaid patients. The recruiters falsely told prospective enrollees that they would not have to switch doctors.

In Tennessee the recruiting company hired by a Tenncare HMO (Tennessee's Medicaid program) excluded people with physicial problems and pregnant women when it went door-to-door trying to enroll people in the HMO. This same recruiting company went to jails and homeless shelters, enrolling individuals who were not eligible.

In another instance, New York recruiters threatened Medicaid recipients with falsehoods if they did not enroll in the HMO (Medicaid was "coming to an end;" they had to enroll immediately

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attributable to delivery of goods or services).

[81]Comments of Carolyn McElroy, Director Medicaid Fraud Control Unit Maryland, 1997 ABA National Institute on Health Care Fraud, May 2, 1997.

or risk losing their medicaid coverage).[82]

C. The health care fraud being committed is becoming more complex.

Whatever the type of reimbursement system, fee for service or managed care, the health care fraud being committed is becoming more complex: involving more defendants, spanning a wider geographical area, and often involving seasoned criminal organizations.

Ten years ago I conducted a survey of all federal and state prosecutions of health care health care providers, as reflected in reported court opinions.[83] Allowing for bias in this survey (cases resulting in pleas of guilty and acquittals were not included), one observation was clear. Most of the prosecutions were of one defendant, usually a single health care provider, for a fairly straightforward and simple fraud. In this sample of prosecutions, twenty different types of providers were prosecuted as defendants, but three types accounted for most (67 %) of the convictions: 47 % physicians; 10 % pharmacists; and 10 % nursing homes or nursing home employees. Corporate defendants were named in only 6 % of the prosecutions. Most of the frauds committed were by physicians writing prescriptions for controlled substances that were not medically necessary, billing for services not provided or misrepresenting what services were provided.[84]

Closer examination shows how simple these frauds were. Typical prosecutions of billing for services not provided included a pharmacist convicted for billing for surgical equipment he never supplied,[85] a physician who billed for performing direct laryngoscopies that were never performed.[86] Similarly, misrepresentations of services provided were fairly simple. Typical prosecutions were included: a podiatrist who represented to Medicare that he treated patients for complex and compensable podiatric ailments when in fact he had merely trimmed toenails or performed other noncompensable services [87] optometrists who sold noncompensable sunglasses to patients but claimed they had supplied compensable cataract eye-glasses,[88] physicians who represented that they provided compensable injections for joint pain but actually supplied noncompensable injections of

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[82]Sharon L. Davies & Timothy Stoltzfus Jost, *Managed Care: Placebo or Wonder Drug for Health Care Fraud and Abuse?* 31 GEORGIA L.REV. 373 (1997).

[83]*Fraud By Fright, supra* note 15, 67 N.C.L.REV. at 855.

[84]Bucy, *Fraud by Fright, supra*, 67 N.C.L.Rev. 855.

[85]United States v. Hershenow 680 F.2d 847 (1st Cir. 1982).

[86]People v. American Medical Centers, 118 Mich. App. 135,324 N.W. 2d 782 (1982). etc.

[87]United States v. Rousseau, 534 F.2d 584, 585 (5th Cir. 1976).

[88]United States v. Gold, 743 f.2d 800, 808-09 (11th Cir. 1984)

routine vitamins or medicines[89] a shoe store proprietor who claimed he supplied compensable orthopedic shoes "to be attached to a leg brace," but in fact supplied ordinary, noncompensable street shoes.[90]

By contrast, today the prosecutions are more complex. The National Health Laboratories (NHL) case is a good example. In 1992, NHL reached the largest settlement to date on Medicare fraud charges. Operating in 41 states, NHL was one of the largest blood testing laboratories in the U.S. It agreed to pay $100 million to settle allegations that it defrauded Medicare and Medicaid by manipulating doctors into ordering medically unnecessary tests for high density lipoprotein (HDL) cholesterol and ferritin (estimated iron storage) whenever doctors ordered a basic blood test series. The corporation pled guilty to presenting false claims to the CHAMPUS program and paid a $1 million fine; the corporate President and CEO pled guilty to submitting false claims to CHAMPUS and Medicaid.[91] (As noted in section I(E) *infra*, by pleading guilty only to CHAMPUS fraud, NHL avoided the exclusion remedy. This option is no longer available after HIPAA.)

The 1996 prosecution of ABC Home Health Services in Georgia also demonstrates the massive scale on which health care fraud is taking place. At the time it was indicted, ABC was the largest privately owned home health care provider in the United States, had 15,000 employees in 22 states and during the time period covered by the indictment, received $900,000,000 in Medicare revenue. Convicted of various felonies for falsely billing Medicare $1.1 million, the corporation was ordered to pay $9.9 million in restitution and fines; its owner, the owner's wife and business partner, and ABC's transportation director were convicted. All received sentences of incarceration. The owner, Jack Mills, received the stiffest sentence of 7½ years in prison and a fine of $10 million. He was also excluded from participating in Medicare and any State health care program for a minimum of 15 years.[92] At issue in the ABC prosecution were some of the more complex cost reporting rules applicable to Part A Medicare providers.[93]

By their nature, health care fraud cases are difficult to prosecute, more so than any other white collar crime. As the frauds become more complex, more geographically spread out and as more organizations are prosecuted, as opposed to simply individuals, these difficulties will increase.

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[89]United States v. Mekjian, 505 F.2d 1320, 1322-23 (5th Cir. 1975); United states v. Russo, 480 F.2d 1228, 1233 (6th Cir. 1973).

[90]United States v. Yosevitch, No. 83-1896 (E.D. Pa. Apr.12, 1983), aff'd 745 F2d 49 (3d Cir. 1984).

[91]1 BNA HEALTH LAW REPORTER 1416 (Dec. 31, 1992).

[92]DEPARTMENT OF HEALTH AND HUMAN SERVICES, OFFICE OF INSPECTOR GENERAL SEMIANNUAL REPORT, APRIL 1, 1996 - SEPTEMBER 30, 1996.

[93]Comments of defense counsel for ABC and prosecutors, 1997 ABA Health Care Fraud.

Most white collar crimes are difficult to investigate and prove.[94] White collar crime is rarely self-evident. Victims of assaults know immediately when they have been assaulted but victims of fraud may never know they have been defrauded.[95] This failure to realize that one has been defrauded is due, in part, to the fact that the perpetrator usually is in a position of trust to the victim. Because of this relationship, a fraud victim has no reason to suspect criminal activity, even when circumstances occur that would otherwise make a crime victim suspicious.

The patient-physician relationship epitomizes such trust.[96] "Often in pain, fearful of death, the sick have a special thirst for reassurance and vulnerability to belief." As one Blue Cross official said, "Americans canonize doctors."[97] A recent Gallup poll reveals that Americans respect physicians more than any other occupation.[98] This deference, a twentieth century phenomenon, can have a very real effect on any attempt to prove fraud. One sees it in the attitudes of jurors and courts. For example, a New York appellate court reversed the conviction of a physician because it did not believe a wealthy physician would defraud the government, saying

> Perhaps the most questionable [part of the Government's case] is the realism of a theory that a doctor, specializing in obstetrics and gynecology who...had a practice so extensive that he delivered more babies than any other doctor in the hospital with which he was affiliated, who during the years in question...billed Medicaid for over $100,000 a year...he would steal a few hundred dollars....[99]

The ambiguous nature of medicine perpetuates this deference. Unlike banking, securities,

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[94]"White Collar Crime: Hearing before the Senate Comm. on the Judiciary, Part 1," 99th Cong., 2d Sess. at 27 (1986) (Testimony of United States Deputy Attorney General D. Lowell Jensen); Clinard & Yeager, *Corporate Crime* 95 (1980); Conklin, *Illegal But Not Criminal* 17-18 (1977); Finn & Hoffman, *Prosecution of Economic Crime* 4 (1976); Gardiner & Lyman, *The Fraud Control Game* 87 (1984).

[95]Bequai, WHITE COLLAR CRIME: A 20TH CENTURY CRISIS 13 (1978); Sutherland, WHITE COLLAR CRIME: THE UNEXPURGATED VERSION 232 (1983); Edelhertz, *The Nature, Impact and Prosecution of White Collar Crime*, CRIME AT THE TOP 51 (1978).

[96]*See, e.g.*, Mechanic, *Some Dilemmas in Health Care Policy*, 59 MILBANK MEMORIAL FUND Q. 1, 4 (1981) ("Feeling highly dependent on such relationships, the typical patient has a strong need to see [his own physician] as an ally."); Marmor, Boyer & Greenberg, *Medical Care & Procompetitive Reform*, 34 VAND. L. REV. 1003 (1981).

[97]Clark, *The Question of Costs*, MEDICAL CARE IN THE UNITED STATES 40 (Oatman ed. 1978).

[98]N.Y. Times, Aug. 22, 1976, at 32, col. 7.

[99]People v. Alizadeh, 87 A.D.2d 418, 428, 452 N.Y.S.2d 425, 431 (N.Y. App. Div. 1982).

taxation, or, to some extent, labor relations, where legally appropriate behavior is carefully and precisely delineated, appropriate behavior in the practice of medicine is unclear and subjective.[100] History has shown that a medical procedure seen today as fraudulent quackery may be recognized as an important cure in the future.[101]

In some instances the prosecutor may find that this deference is a blessing in disguise. For example, in *State v. Carr*[102] the prosecutor was allowed to introduce "graphic evidence regarding the defendant's sexual relationships with [some of his patients], the suicidal tendencies and deaths of these women, and the explicit descriptions of [their] deteriorating physical condition."[103] Although not relevant to the offenses charged, the court held that this evidence was "particularly important...because of the medical issues involved and the deference and respect which would ordinarily be given to a physician's opinion."[104] Similarly, in *United States v. Johnson*,[105] the defendant, a physician, was charged with understating her income to the Internal Revenue Service by $120,000 but claimed that her "inadvertent mistake" occurred because she was an "altruistic healer of the sick, whose concerns lay elsewhere than attending to her financial interests and resulting legal responsibilities."[106] In response, the government was allowed to introduce a study of the defendant's billings for Medicaid services which revealed that she billed four times as many services per patient than did any other Virginia doctor.[107]

In addition to the unsuspecting naivete of victims, the fact that the crime is usually hidden in voluminous documentary materials also makes white collar crime difficult to investigate and prove. It is often necessary to follow a lengthy paper trail simply to discover what occurred. This paper trail is especially arduous in the health care field because of complex and rapidly changing regulations. As one expert noted, "The billing process itself, and the paperwork necessary to monitor numerous and complex third-party insurance contracts—with varying co-insurance, deductibles, and maximum benefit schedules and with widely varying coverage and criteria for major medical

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[100]Donabedian, *The Quality of Medical Care*, in MEDICINE IN A CHANGING SOCIETY 85-86 (1972); Friedman & Rakoff, *Health, Health Costs and Public Policy*, TOWARD A NATIONAL HEALTH POLICY, 3-4 (1977).

[101]*See, e.g.*, West v. United States, 68 F.2d 96, 98 (10th Cir. 1933).

[102]95 N.M. 755, 626 P.2d 292 *cert. denied*, 454 U.S. 853 (1981).

[103]*Id.* at 772, 626 P.2d at 309.

[104]*Id.* at 767, 626 P.2d at 304.

[105]634 F.2d 735 (4th Cir. 1980).

[106]*Id.* at 736.

[107]*Id.* at 736-37.

payments—boggle[s] the mind.... [I]t assuredly confuses both patients and their doctors."

While many white collar crimes involve complex statutes and regulations, the complexity of regulations in the health care industry is exacerbated by several facts unique to this industry. Health care regulations change more often than those in most fields.[108] In addition, a single provider usually deals simultaneously with several third-party providers and is subject to the varied and often inconsistent rules and regulations promulgated by each. Because of the third-party reimbursement mechanism, all providers must utilize these voluminous, changing, inconsistent rules and regulations to obtain reimbursement for performing even a minor procedure. To prove even the smallest fraud involves tracking hundreds of such regulations.

The complexity of the regulations gives rise to a credible defense by otherwise intelligent, informed professionals that they simply did not understand or were unaware of essential regulations that govern their day-to-day transactions.

Another reason white collar crime is difficult to investigate and prove is that it is often "hidden within an organization." This is even more true recently as health care fraud schemes have increased in "sophistication and complexity."[109] In the 1980's, when authorities first began focusing on health care fraud, most of the cases involved "individual providers filing false claims for relatively low dollar amounts."[110] In the past few years, however, the schemes have "changed dramatically" because "organized criminal enterprises have penetrated virtually every legitimate segment of the health care industry."[111]

The fact health care fraud is hidden within an organization makes it difficult to find out what went on and particularly difficult to find evidence of a defendant's intent. In the health care field, fraud occurs when false bills are submitted for reimbursement by the provider to the third-party payer. This billing process usually involves a number of people apart from the provider, such as a receptionist, billing clerk, nurse, or computer billing service. Once the claim reaches the provider it is again processed by multiple individuals and computer services. To hold the provider

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[108]Because of the complexity of the Medicare and Medicaid programs and the attempt by all insurers, public and private, to address the problem of rising costs, the regulations governing health care have been changing rapidly. For example, between 1980 and 1987, Congress enacted more than 30 laws governing just the Medicare program. Roper, *Balancing Efficiency and Quality--Toward Market-Based Health Care*, 3 NOTRE DAME J.L. ETHICS & PUB. POL'Y 169, 171 (1988).

[109]"Health Care Fraud, Hearing before the Senate Select Comm. on Aging," 104th Cong., 1st Sess. ____ (Mar. 21, 1995) (Prepared statement of Inspector General June Gibbs Brown, Dept. of Health and Human Services).

[110]*Id.*

[111]*Id.* at ____ (Prepared statement, FBI Director Louis J. Freeh).

responsible for the false statements in the bills requires a step-by-step analysis of the billing process and proof that the provider personally knew false information was included in the bills finally submitted.

The reported cases indicate that a defense that places the blame on others in the organization has little chance of success. The Eleventh Circuit's treatment in *United States v. Hilliard*[112] is a typical judicial reaction to such a claim. The appellant, a nursing home administrator, argued that her conviction for submitting false claims should be reversed because it was her codefendant who actually submitted the false Medicare claims. The United States Court of Appeals for the Eleventh Circuit summarily dismissed this argument and affirmed the conviction on the ground that there was evidence sufficient for a reasonable juror to find appellant was aware of and participated in the scheme to defraud Medicare.[113] Like the other difficulties in proving fraud by health care providers, the impact of the organizational structure is felt in the decision not to prosecute certain cases. Richard Kusserow, the a former federal law enforcement officer charged with prosecuting fraudulent health care providers, stated that:

> Particularly with the health-care practitioners, we find that the...standard defense they come up with is...that they are healers and not businessmen [and] they will lay it off on their clerical staffs and say that they were really too busy dealing the medical problems to pay much attention to the business side.[114]

A last factor complicating proof that a health care provider has committed fraud is unique among white collar crimes. Often each criminal transaction by a health care provider involves a de minimus amount of money.[115] Felony prosecutions have been reported where the losses resulting

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[112]752 F.2d 578, 581 (11th Cir. 1985).

[113]*Id.* at 581; See also United States v. Blazewicz, 459 F.2d 442, 443 (6th Cir. 1972) (in affirming the conviction of a physician for submitting false claims to Medicare, the court noted that "[a]pparently the jury rejected the defense that [the physician] did not authorize the filing of the claims...."); United States v. Witschner, 624 F.2d 840, 842 (8th Cir. 1980) (in affirming the conviction of an attorney for submitting false insurance claims, court noted that attorney's defense at trial, which was rejected by the jury, was that his clients' physician falsified the claims without the attorney's knowledge).

[114]"Program Fraud Civil Penalties Act of 1983: Hearings before the Senate Comm. on Gov't Affairs," 98th Cong., 1st Sess. 7 (1983) (Testimony of Hon. Richard P. Kusserow Inspector General, Dept. of Health and Human Services).

[115]"Oversight of HHS Inspector General's Effort to Combat Fraud, Waste and Abuse: Hearings before the Senate Comm. on Finance and Senate Select Comm. on Aging," 97th Cong., 1st Sess. 117 (1981) (Statement of Donald P. Zerendow, Chief, Massachusetts Medicaid Fraud Control Unit).

from the fraud were as small as $882.21,[116] $2,15.60,[117] and $809.00.[118] The amount of money per fraudulent transaction is small because the standard billing process in the health care industry requires an itemization of each service or each component of a service. Such itemization is perpetuated, in part, by the fee-for-service method of calculating reimbursement that necessitates incremental billing. As a result of this billing practice, each false claim submitted by a provider may involve only a few cents of fraud. The prosecutor must plead and prove many such fraudulent transactions to reach a large aggregate loss.

Sometimes the smaller amounts reflect only the tip of the iceberg of the dollar loss actually caused by a provider's fraud.[119] However evidence that the amount at issue is only the "tip of the iceberg" may never get to the jury. When it does not, the de minimis character of the fraudulent transaction adversely affects the prosecution of fraudulent providers for even when presented with overwhelming evidence of intentional fraud, the de minimis amount of loss makes it difficult for a jury to convict.

To overcome the problem caused by the de minimis dollar loss in a single transaction, investigations should expand to include hundreds of false claims submitted by a provider. In addition to increasing the dollar amount of the fraud, expanding the case may also benefit the prosecution by revealing a more extensive pattern of fraud by the provider. Expanding the case to include additional de minimis transactions, however, is often as difficult as expanding the investigation of other white collar crimes to include multi-million dollar transactions.

Although certain features of white collar crime by health care providers make these crimes difficult to investigate, other features of health care provider fraud may assist the prosecutor in proving such fraud. One feature is a type of evidence which is uniquely available in the health care industry because of the presence and resources of the third-party payer. Known as a "peer group analysis," this evidence results from comparing the billing history of the defendant provider to peer providers.[120] A large computerized data base with information on many providers is necessary for a credible comparison, and third-party payers maintain such data bases. An aberrational service history on the part of one provider, when compared to that of its peer providers, can help target

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[116]See United States v. Larm, 824 F.2d 780, 782 (9th Cir. 1987).

[117]United States v. Matanky, 482 F.2d 1319, 1324 (9th Cir.) *cert. denied*, 414 U.S. 1039 (1973).

[118]State v. Page, 32 N.C. App. 478, 480, 232 S.E.2d 460, 461 (1977).

[119]*Matanky*, 482 F.2d at 1324 n.3.

[120]United States v. Alexander, 748 F.2d 185, 188 (4th Cir. 1984) *cert. denied*, 472 U.S. 1027 (1985).

fraudulent providers for further investigation. Such a comparison also can be potent trial evidence.[121]

United States v. Russo[122] demonstrates use of peer group comparisons at trial. Two osteopathic physicians were charged with misrepresenting the type of service they allegedly provided to patients.[123] The government introduced a peer group comparison conducted by Blue Cross/Blue Shield through its data base. The comparison demonstrated that of the claims for the five procedures at issue filed by 10,000 physicians in the same geographical area, the two defendants submitted twenty-eight percent of the total claims.[124] The court found this evidence relevant to the charges that the defendants misrepresented the services for which they claimed reimbursement.[125]

A second feature unique to fraud by health care providers that may make these prosecutions, if not less complex, at least more likely to succeed is the presence of patients as victims of the fraud. The victim of many white collar crimes—often a corporation, conglomerate, governmental entity, or business person—is often perceived by the public or a jury as just as greedy and ruthless as the defendant. In short, the victim of many white collar crimes does not engender much sympathy. By comparison, all too often the victim of the fraudulent health care provider is not only the third-party payer that lost money, but also the patient who, by definition, is ill, perhaps old, and who received inadequate, incompetent, or unnecessary medical services. By incorporating the patient as a victim into the theory of the case, it is possible to overcome many of the problems otherwise presented in prosecutions of health care providers while also demonstrating a more accurate portrayal of the harm caused by the provider's fraud.

D. The Notion of Health Care Fraud is Evolving.

Nothing demonstrates this better than the anti-kickback and Stark statutes. Both of these statutes address referral practices by health care providers. Over the past twenty years considerable attention has been devoted this issue, primarily at payments by providers to other providers and at "self-referrals," wherein a provider refers patients to entities with which the referring provider has a financial relationship.

In other occupations, referral fees are a customary and expected way of doing business.

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[121] *Id.* at 188-89. But see People v. Louie, 158 Cal. App. 3d Supp. 28, 45, 205 Cal. Rptr. 247, 260-61 (Cal. App. Dep't Super. Ct. 1984) (conviction reversed; court found peer comparison evidence insufficient to convict physician).

[122] 480 F.2d 1228 (6th Cir. 1973).

[123] *Id.* at 1232.

[124] *Id.* at 1234-36.

[125] *Id.* at 1243.

Vertical integration, whereby one business owns those which supply it with products, also is an accepted business structure, usually viewed as desirable. Likewise, there may be legitimate reasons a provider might own another provider. For example, a group of physicians may see a need for an imaging center in their community - or see the current imaging center run incompetently and know they can do better. In these instances, it could be an act of community service for physicians to build or buy an imaging center. Or, perhaps a physician wants to ensure that the laboratory work on her patients is done competently and quickly. So, she allows a laboratory whose work she respects to build a laboratory and place an employee on site at her office. The laboratory pays the physician rent.

Or, the above examples, may not be legitimate or undertaken in good faith. The physicians owning the imaging center may consciously, or unconsciously, increase their referrals to meet, or surpass, budget. The laboratory may pay the physician too much for rent—a sizable thank you for the referrals. It is this prospect—affecting medical judgment, at which the anti-kickback and stark laws are aimed. Unlike the automobile company that acquires its supplies but is subject to the buying ability and desire of the public, physicians control the volume of "supplies." This ability to adjust volume to profit rather than to medical necessity is the reason for the anti-kickback and Stark laws.

The point is that legitimate or not, the above examples could violate the antikickback or Stark statutes. Congress and HHS, through its regulations, have attempted to atrick a balance in regulation by enacting a ban on remunerations for referrals while permitting remunerations if they fit within specific, enumerated safe harbors. Violations of the anti-kickback statute can be a criminal offense, grounds for an action under the False Claims Act, and the basis for civil monetary penalties and grounds for exclusion.[126] Stark I and II[127] prohibit physicians from referring Medicare and Medicaid patients to eleven types of providers (clinical laboratories, physical therapy services, occupational therapy services, radiology or other diagnostic services, etc.) Violation of Stark is not a crime but is grounds for civil monetary penalties and exclusion.

It is not clear that the current balance is optimal. Over regulation, especially when it carries the potential for criminal liability, chills creative efforts to restructure a profession—efforts which are needed in a profession in flux. It also forces providers to incur substantial legal costs in seeking legal advice on how to devise the simplest business arrangements. Expanding criminal liability into a heavily regulated area is especially ominous where corporations exist. Given the broad principles of corporate criminal liability in American law, corporations become strictly liable for criminal acts

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[126]42 U.S.C. § 1320a-7(b)(7), 42 C.F.R. § 1001.952(a).

[127]Ethics in Patient Referrals Act, Omnibus Budget Reconciliation Act of 1989, Pub. L. No. 101-239, § 6204, 103 Stat. 2137, 2236 (codified at 42 U.S.C. § 1395nn).

committed by their agents, even if the agents act in disregard of explicit instructions.[128] This is bad for business and bad for the criminal justice system. Overcriminalization cheapens the criminal law and erodes its ability to serve as one of the more powerful tools of control society has.

A recent flurry of case law regarding the anti-kickback statute demonstrates the problem in regulating referral behavior in health care. In 1995, the United States Court of Appeals for the Ninth Circuit in *Hanlester Network v. Shalala*,[129] reversed the permissive exclusion of health care providers on the ground that the government had not proven all elements of the anti-kickback offense. This case is one of the first to address the intent element of the anti-kickback statute subsequent to recent Supreme Court decisions discussing intent in white collar crimes. The Ninth Circuit ruled that to prevail on an anti-kickback claim the government must prove the highest level of intent: that the defendants acted "willfully," with "specific intent to do something which the law forbids."[130] In 1996, the United States Court of Appeals for the Eighth Circuit rejected the Ninth Circuit's approach but adopted a standard tougher than that urged by the government (ignorance of the law is no excuse) and held that a "middle ground" was appropriate. The court held that the government must prove that the defendants violated the anti-kickback statute "unjustifiably and wrongfully" ... knowing that the "conduct was unauthorized."[131] Lower courts have rejected the Ninth Circuit's approach without clearly stating an alternative.[132]

This see-sawing by the courts on a key element of the anti-kickback statute is not the usual split among the circuits on a principle of law. It is symptomatic of difficulties encountered when the law, especially a criminal law, is stretched too far.

E. A joint criminal/civil approach is used increasingly to tackle health care fraud.

Significant legislation in the 1980s has changed the way health care fraud is prosecuted, and could well serve as a model for pursuing all white collar crime. This legislation has made civil and administrative avenues for pursuing the fraudulent health care provider more viable. The result is a comprehensive arsenal of criminal, civil and administrative sanctions and investigative tools from which law enforcement can choose, depending on the circumstances of the case. Law enforcement

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[128]V. S. Khanna, *Corporate Criminal Liability: What Purpose Does It Serve*, 109 HARV.L.REV. 1477 (1996); Pamela H. Bucy, *Corporate Ethos: A Standard for Imposing Corporate Criminal Liability*, 75 MINN.L.REV. 1095 (1991).

[129]51 F.3d 1390, 1400 (9th Cir.1995).

[130]Hamlester Network v. Shalala, 51 F.3d 1390, 1400 (9th Cir. 1995).

[131]United States v. Jain, 93 F.3d 436 (8th Cir. 1996).

[132]*See, e.g.*, United States v. Neufeld (D.C.S.Ohio) CR 2-94-144; (Nov. 27, 1995); United States v. Metzinger, No. 94-7520 (June 12, 1995).

can investigate a situation, determine which level of sanctions, if any, fit the conduct and the intent and seek whichever seems appropriate. Given the difficulty of determining criminal intent in almost any health care fraud situation, this flexibility is perfectly suited to white collar crime in general, but especially health care fraud. Health care providers often claim, however, that this flexibility becomes abusive and allows law enforcement to extort unwarranted settlements.

1. Recent Legislative Initiatives which blend criminal, civil and administrative law.

Legislation in three areas has made civil and administrative sanctions formidible: civil monetary penalties, civil damages, and exclusion.

First instituted in 1981, the Secretary of HHS was given authority to impose civil monetary penalties upon providers for actions that jeopardize the Medicare and Medicaid programs but are not serious enough to warrant a civil suit under the False Claims Act or criminal prosecution. In 1996, the Health Insurance Portability and Accountability Act (HIPAA) substantially increased this authority, adding additional grounds for imposition of civil monetary penalties and increasing the amount of the penalty to $10,000 for most violations.

In 1986, the False Claims Act[133] was amended to make its qui tam provisions more appealing. Initially passed in 1863, the False Claims Act (FCA) was used little prior to 1986 primarily because the intent element was interpreted strictly and the qui tam provisions were unappealing or unavailable. In 1986, however, Congress invigorated the FCA as a major fraud-fighting tool. High profile frauds had convinced many that new and innovative tools were needed to combat fraud. As Senator Cohen explained:

> Fraud in federal programs is pervasive, affecting benefit and assistance programs, as well as programs for mortgage insurance, crop subsidies, disaster relief and the like. Procurement fraud, in particular, has seemingly flourished in the past few years with the plethora of reports on mischarging, cross-charging and egregious overcharging. ... The consequence ... is that the federal government loses 'tens, if not hundreds, of millions of dollars' to fraud each year. Beyond the actual monetary loss, fraud in federal programs also erodes public confidence in the administration of these programs by allowing ineligible persons to benefit from them."[134]

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[133] 31 U.S.C. § 3129 et seq.

[134] *False Claims Act Amendments: Hearings before the Subcomm. on Administrative Law & Gov't Relations, House Comm. on Judiciary*, 99th Cong., 2d Sess. 296-98. (Statement of Senator William S. Cohen)

Congress responded by substantially amending and strengthening the FCA. These amendments (1) provided more effective investigative tools to detect civil fraud, (2) defined the mens rea requirement to make clear that specific intent was not required proof, (3) established "preponderance of the evidence" as the applicable burden of proof (4) increased the penalties and damages, (5) broadened the venue and jurisdiction provisions so as to cover multi-defendant and multi-district frauds, and (6) broadened the definition of "claim." The 1986 amendments also made it more attractive and feasible to serve as a qui tam plaintiff by (1) making it easier to qualify as a qui tam plaintiff, (2) enlarging the role of the qui tam plaintiff even if the government was also a plaintiff, (3) guaranteeing minimum recoveries to successful qui tam plaintiffs, (4) providing whistleblower protection to any employee (whether a qui tam plaintiff or not) who "assisted in the FCA case."[135] In combination, these changes invigorated the FCA, converting it into a formidable weapon against fraud upon the government. Between 1986, after the FCA was amended, and 1996, total fraud recoveries by the federal government exceeded $3 billion. Of this amount $1.13 billion has been recovered as a result of FCA actions filed by private persons.[136]

In 1987, passage of the Medicare and Medicaid Patient and Program Protection Act (MMPPPA) substantially expanded the authority of the Secretary of the Department of Health and Human Services to exclude from participating in Medicare and Medicaid providers who had committed certain acts, including fraud upon these programs. Although exclusion authority had existed since 1965, the MMPPPA strengthened this remedy considerably by requiring mandatory exclusion for certain acts and increasing the grounds for permissive exclusion. Passed in 1996, the Health Insurance Portability and Accountability Act of 1996 (HIPAA) made exclusion even tougher, adding grounds for mandatory exclusion and setting minimum periods of exclusion for many of the permissive exclusions.

Although nothing compares to loss of liberty, these administrative and civil sanctions: civil monetary penalties, civil suits under the False Claims Act and exclusion, can wreck almost as much havoc on a health care provider as criminal prosecution.

2. Investigative Tools.

The investigative tools available to law enforcement through recent legislation enhance this flexibility. The Inspector General Act and HIPAA both expand the options available to investigate health care fraud.

The grand jury subpoena is the classic investigative tool used in criminal investigations. With a grand jury subpoena, there is no need to demonstrate probable cause, or any basis at all for

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[135]PAMELA H. BUCY, HEALTH CARE FRAUD: CRIMINAL, CIVIL AND ADMINISTRATIVE LAW, § 4.01 (1996).

[136]TAXPAYERS AGAINST FRAUD, THE 1986 FALSE CLAIMS ACT AMENDMENTS, 1986-1996, 19 (1996).

seeking the information set forth in the subpoena.[137] Moreover, when the witness appears in the grand jury, her counsel can not be present. In these respects grand jury subpoenas are a favored investigative tactic of prosecutors. However, grand jury subpoenas have a major drawback for law enforcement. The information obtained through them can be disclosed only to attorneys and agents working on the criminal case. Thus, it is not possible to utilize civil government attorneys or agents to analyze the data, nor is it possible to turn the grand jury material over to administrative agencies or private insurers for analysis.[138]

Search warrants are another favored investigative tool of law enforcement for criminal matters. With search warrants, there is more flexibility than with grand jury subpoenas, in terms of who may have access to such material, but search warrants require a court's prior approval upon a showing of probable cause that the items sought are evidence of a crime and are likely to be where the agents are seeking to search. Search warrants also require a return of the inventory to the court of items found and seized.[139]

Lastly, wire taps, also used in some criminal investigations, often yielding evidence which can be obtained no other way. However, wire taps require a court order, upon substantial proof of probable cause and need, and have strict reporting and disclosure requirements.[140]

Thus, while powerful tools for the government in criminal investigations, all of these investigative techniques have limitations. For this reason, two investigative tools available in administrative and civil cases have been used with increasing frequency by the government in investigating health care fraud. The False Claims Act includes a provision for use of a civil investigative demand (CID) as does RICO.[141] The Health Insurance Portability and Accountability Act of 1996 (HIPAA) gave CID authority to the Attorney General for health care fraud cases in general.[142] The CID authority in these statutes permits the Attorney General to seek, by subpoena, records which may be relevant to an authorized law enforcement inquiry. The CID authority varies slightly in these three statutes. RICO and HIPAA give the Attorney General authority to seek documentary materials only (and oral testimony only of a custodian of the records as needed to

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[137]United States v. R. Enterprises, Inc., 498 U.S. 292 (1991).

[138]See generally SARA BEALE AND WILLIAM BRYSON, GRAND JURY LAW AND PRACTICE §§ 7:01-7:31 (1994); United States v. Sells Engineering, Inc., 463 U.S. 418 (1983); FRCrP6(e); PAMELA H. BUCY, HEALTH CARE FRAUD: CRIMINAL, CIVIL AND ADMINISTRATIVE LAW § 6.03 (1996).

[139]BUCY, HEALTH CARE FRAUD, *supra* note 150 at § 6.06.

[140]18 U.S.C. § 2510 et seq.

[141]18 U.S.C. § 1968.

[142]Pub. L. 104-191, 248, creating 18 U.S.C. § 3486.

authenticate them) whereas the False Claims Act gives the Attorney General the authority to seek records, answers to interrogatories and oral testimony.[143]

In addition to the CID, the Secretary of HHS may serve administrative subpoenas known as Inspector General (IG) subpoenas. The Inspector General (IG) of HHS has the power "to require by subpoena attendance and testimony of witnesses and production of any other evidence at an investigational inquiry."[144] IG subpoenas may be employed to investigate fraud in Medicare, Medicaid and other state health care programs.

Because the IG has authority to investigate civil and criminal violations of the law, and because there is no requirement of secrecy for material collected by the IG, information obtained with IB subpoenas may be used in administrative, civil or criminal proceedings.[145] This flexibility is the major advantage for a federal investigators and prosecutors in using IG subpoenas rather than grand jury subpoenas.

Although the scope of an IG subpoena is similar to a grand jury subpoena in that neither requires proof of relevancy or probable cause for issuance,[146] the investigational inquiry pursuant to an IG subpoena is substantially different than that required by a grand jury subpoena. As noted *supra*, defense attorneys are not permitted to appear with their clients in grand jury proceedings. If a grand jury witness wishes to consult with his or her attorney, the witness must leave the grand jury proceedings to do so.[147] At an investigational inquiry pursuant to an IG subpoena, however, the witness may be accompanied and advised by counsel. Counsel may object to questions on the record although all questions must be answered, unless the objection is on the ground of privilege. A witness is also given the opportunity to "clarify his other answers on the record following the questions by the [IG]."[148] The witness is entitled to review the transcript of the proceeding and

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[143]31 U.S.C. § 3733.

[144]42 C.F.R. § 1006.1(a). An IG subpoena should state the name of individual entity to whom it is addressed; the statutory authority for the subpoena; the date, time and place of the investigational inquiry; and a "reasonably specific description" of documents or items required to be produced. If the IG subpoena is addressed to an entity, it should "describe with reasonable particularity the subject matter on which testimony is required" so that the entity can name an individual(s) to testify who are familiar with the area at issue. 42 C.F.R. § 1006.2.

[145]United States v. Medic House, Inc. 736 F.Supp. 1531, 1537 (W.D.MO.1989).

[146]United States v. Morton Salt Co. 338 U.S. 632, 652, 70 S.Ct. 357, 368, 94 L.Ed. 401, 416 (195).

[147]BUCY, HEALTH CARE FRAUD, *supra* at § 6.03.

[148]42 C.F.R. § 1006.4.

submit written proposed corrections to the transcript.[149]

If a witness refuses to appear at the IG investigational hearing, participate as required in the hearing, or produce requested records, the IG may file a petition for enforcement of the subpoena with a federal district court.[150] The court is required to enforce the subpoena if it si within the authority of the agency, the demand is sufficiently definite, the information sought is "reasonably relevant" to the agency's inquiry, and the information is not already in the government's possession.[151]

Focusing on the authority given to the IG by Congress, courts have held that the IG has "broad latitude" in deciding which materials are relevant.[152] According to the Supreme Court, the scope of the inquiry by an administrative agency is "analogous to the Grand Jury, which does not depend on a case or controversy for power to get evidence but can investigate merely on suspicion that the law is being violated, or even just because it wants assurance that it is not."[153] Once the IG establishes a prima facie case for enforcement, the burden shifts to the part opposing the subpoena to show that enforcement would be an abuse of the court's process.[154]

Unlike the grand jury subpoena, search warrant and wire tape, CIDs and IG subpoenas allow sharing of information among administrative government agents, private insurance fraud investigators and law enforcement agencies. Together, these groups can investigate a case and decide after the investigation is complete which, if any, of the many avenues should be pursued:

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[149]42 C.F.R. § 1006.4.

[150]28 U.S.C. § 1345; U.S.C. Appendix § 6(a)(4).
See, e.g.:
Third Circuit: United States v. Westinghouse Electric Corp., 615 F.Supp. 1163, 1163 (W.D.Pa.1985), *aff'd* 788 F.2d 164 (3d Cir.1986).
Eighth Circuit: United States v. Medic House, Inc., 736 F.Supp. 1531, 1533 (W.D.Mo.1989).

[151]United States v. Medic House, Inc., 736 F.Supp. 1531 (W.D.Mo.1989) *citing* United States v. Morton Salt Co., 338 U.S. 632, 652, 70 S.Ct. 357, 368, 94 L.Ed. 401, (1950) and 416 United States v. Powell, 379 U.S. 48, 58, 85 S.Ct. 248, 255, 13 L.Ed.2d 112 (1964).

[152]*Third Circuit*: United States v. Westinghouse Electric Corp., 615 F.Supp. 1163, 1181 (W.D.Pa.1985) *aff'd* 788 F.2d 164 (3d Cir.1986) *citing* United States v. Arthur Young & Co., 465 U.S. 80-85, 104 S.Ct. 1495, 1502, 79 L.Ed.2d 826 (1984).

[153]United States v. Morton Salt Co., 338 U.S. 632, 642-43, 70 S.Ct. 357, 363-64, 94 L.Ed. 401 (1950).

[154]United States v. Balanced Financial Management, Inc., 769 F.2d 1440, 1444-45 (10th Cir.1985).

criminal prosecution, civil suit for damages, civil monetary penalties or exclusion. Interestingly, some of the changes made by HIPAA will take away some of this flexibility. For example, HIPAA expanded the exclusion authority to fraud in CHAMPUS. It also established a minimum period of exclusion for a number of the permissive exclusions. These changes would make the settlement in the National Health Laboratories (NHL) case for example, unworkable since NHL plead guilty to a CHAMPUS offense, not a "program" (Medicare/Medicaid) offense, thereby avoiding exclusion.

The hybrid criminal/civil approach now possible to pursue health care fraud is commendable. It gives law enforcement needed flexibility to involve experts throughout its investigation who otherwise would not have access to information gathered in the investigation. It also allows law enforcement to better tailor the sanction to the deed done. In short, this array of sanctions appropriately recognizes the gray area of health care fraud for this fraud does not quite fit either criminal or civil law.

However, the flexibility can lead to abuse. The national initiatives recently or currently employed have drawn this criticism. Teaching hospitals complain that they have no choice but to settle as part of the PATH initiative for fighting the charges is suicidal. In response to the "Ohio Hospital Project," which is investigating 185 acute care hospitals in Ohio for alleged unbundling of laboratory tests, the Ohio Hospital Association and the American Hospital Association have sued HHS. On October 7, 1996 these groups filed suit against HHS "to stop HHS from retroactively applying billing policies that were not properly established or communicated; and [to] prohibit the government from using the False Claims Act for what the government used to consider to be billing errors."[155]

In Part II of these comments, I suggest ways to maintain this flexibility while curbing the potential for abuse.

F. Cooperation with private parties.

There are three major ways that law enforcement is working with private parties to combat health care fraud. The first is through the "private attorney general" statutes: the qui tam provisions of the False Claims Act and civil RICO. Both of these causes of action encourage private parties to detect and prove fraud by rewarding the victorious party with large statutorily set damages. As noted in I(E) *supra*, the False Claims Act has been particularly successful in this respect, especially since the 1986 amendments.

The second way law enforcement has been working with private parties is by cooperating with private insurers who are also victims of health care fraud. Private insurers pay about 35 % of the roughly $1 trillion spend on health care each year in the United States (patient out of pocket

[155]5 BNA, Health Law Reporter 1479 (Oct. 10,1996).

payments for co-payments and deductibles account for about 20%).[156] HIPAA formalized this cooperative relationship between law enforcement and private insurers by requiring closer cooperation and sharing of data.

Both of the above methods of enlisting private resources to combat health care fraud are laudable and should be continued, with some modifications (discussed in Part II).

The third way in which private insurers have been involved in the battle against health care fraud has not worked well and should be changed. When Medicare and Medicaid were created in 1965, the federal and state governments began contracting with private insurers (termed "carriers" and "intermediaries") to process claims submitted by providers and patients. Carriers and intermediaries have been given the "front line" duty of deterring and detecting health care fraud upon these programs. By contract, these organizations are to devise methods of detecting fraud. They even have the power to suspend payments to providers upon reason to believe that the provider is engaged in health care fraud.

For two reasons, however, this system of delegating to carriers/intermediaries the duty of monitoring fraud does not work and is largely to blame for much of fraud in Medicare and Medicaid. The first reason is that detection of fraud is inconsistent with the major contractual duty required of carriers and intermediaries. These insurers are to process claims, quickly and efficiently. Slowing down the processing of claims to investigate fraud is not efficient and causes complaints by providers and complaints by providers jeopardizes the contract of the carrier/intermediary. As noted expert Malcolm Sparrow has explained, "the fiscal-intermediary system focuses mainly on making sure that claims are submitted in a standard fashion, rather than checking whether Medicare is paying for appropriate care."[157]

The second reason that carriers/intermediaries are not viable monitors of fraud is that there is an inherent conflict in interest in expecting them to do so. If the carrier/intermediary's fraud detection unit does its job and finds fraud, especially large scale fraud, it makes the carrier/intermediary look incompetent, at best. The carrier/intermediary has, in this situation, paid a lot of claims which it should not have paid which jeopardizes the carrier/intermediary's contract with Health Care Financing Administration at its next renewal - if not before.

Recent cases demonstrate what happens when carriers/intermediaries or their employees sense that their failure, or success, in detecting fraud jeopardizes their contract with Medicare or Medicaid. In May, 1996, Blue Shield of California agreed to pay a $1.5 million fine and plead guilty to three felonies arising from a conspiracy among its' employees to hide the fact that it had processed

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[156]Comments of William J. Mahon, Executive Director of National Health Care Anti-Fraud Association, 5 BNA Health Law Reporter 948 (June 20, 1996).

[157]Sparrow's views described in George Anders, *Estimate of Improper Medicare Costs Soars*, THE WALL ST.J. A2 (June 11, 1997).

fraudulent claims. In this case:

> ...Blue Shield employees in six units of the Medicare Division, including some supervisors, concealed evidence of claims processing errors by altering or discarding documents, replacing documents containing errors with corrected and backdated documents, and structuring supposedly random samples of files to be shown to federal examiners to exclude files with errors.
>
> Employees in Blue Shield's quality assurance unit in the Medicare division also concealed claims processing errors in weekly reports it was required to file with the federal Health Care Financing Administration, according to federal prosecutors.
>
> ...
>
> Blue Shield held a Medicare carrier contract with HCFA - a cost reimbursement contract under which Blue Shield was reimbursed more than $40 million a years since 1988. Blue Shield processed an average of more than 20 million Medicare Part B claims a year.
>
> ...
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> According to the criminal information filed with the plea agreement in federal court, the goal of the employees was to conceal poor performance from HCFA inspectors during their annual contractor performance audits so that Blue Shield would retain its contract.[158]

Similarly, Blue Cross Blue Shield of Florida tried to hide its deficiency in detecting fraud by its providers. In 1994, it agreed to pay $10 million to settle allegations that it mishandled the Part B Medicare claims it was paid to administer. According to the complaint, "BC-BS of Florida knew, but failed to disclose...that GTE [its' data analysis system] lacked the computer capacity to meet the requirements for the contract [to administer Part B Medicare claims.][159]

G. Growth of a New Profession: The Health Care Fraud Expert.

Three recent events: passage of the federal sentencing guidelines, passage of HIPAA, and the general emphasis by law enforcement and private insurers on health care fraud have given rise to the need for a new professional, one who can merge health care, law and accounting.

No organization likes to be convicted of a crime but if it is, the organization can minimize its penalty considerably if it has an effective corporate compliance plan in place. The organizational sentencing guidelines reflect the view that any fine ordered will be based upon the seriousness of the

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[158]5 BNA Health Law Reporter 665 (May 2, 1996).

[159]3 BNA Health Care Reporter 1245 (Sept. 1, 1994).

offense and the culpability of the organization. The seriousness of the offense generally will be reflected by the highest of the pecuniary gain, the pecuniary loss, or the amount in a guideline offense level fine table. Culpability generally will be determined by the steps taken by the organization prior to the offense to prevent and detect criminal conduct, the level and extent of involvement in or tolerance of the offense by certain personnel, and the organization's actions after an offense has been committed. In this sense, the Sentencing Guidelines encourage "good corporate citizenship." Upon a showing that an organization engaged in certain acts of good corporate citizenship, the organization can reduce by 400% its' base fine, which could reach $72.5 million per count.[160]

The key proof of good corporate citizenship is an effective corporate compliance plan. Such a plan should include a system for educating employees about the law, monitoring employees' compliance with the law and establishing realistic avenues for reporting potential problems. Legal and accounting experts in health care fraud are being retained by more health care organizations to establish and monitor these corporate compliance programs.

If the organization - through its corporate compliance program or otherwise - discovers wrongdoing, it can help or hurt itself considerably by how it handles the revelation. There are substantial advantages to conducting an effective internal investigation such as, fulfilling the Board of Directors' fiduciary duty to investigate allegations of fraud and corruption;[161] discovering, before the government or a potential whistleblower makes the discovery of wrongdoing; remedying the problem so that any fraud ceases and does not recur; discouraging possible prosecution; and, minimizing punishment if there is a conviction.[162] There are also hazards: inadvertent waiver of applicable privileges: attorney client, physician patient, work product, fifth amendment; possible obstruction of justice by aggressive pretrial tactics; inexperience in dealing with search warrants; inexperience in negotiating potential charges.[163] Again, health care providers are turning to the new cadre of fraud specialists to conduct these internal investigations so as to avoid these pitfalls.

Lastly, HIPAA encourages the development of entities specializing in detecting and preventing health care fraud. Section 202 authorizes the Secretary of HHS to enter into contracts with entities which will "[r]eview ...activities of providers of services or other individuals and entities furnishing items and services for which payment may be made under this title (including

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[160]Rakoff & Blumkin, "Determining the Fine in Organizational Sentencing," *Corporate Sentencing Guidelines* (Law Journal Seminars-Press 1993).

[161]Block, Barton & Radin, The Business Judgment Rule: fiduciary Duties of Corporate Directors 127 (3rd ed. 1989).

[162]Webb, Tarun & Molo, Corporate Internal Investigations (LJSP 1994).

[163]*Id.*; PAMELA H. BUCY, HEALTH CARE FRAUD: CRIMINAL, CIVIL AND ADMINISTRATIVE ACTIONS § 8.06-8.07 (1996)..

skilled nursing facilities and home health agencies), including medical and utilization review and fraud review...."

II. SUGGESTIONS FOR DETERRING, DETECTING AND INVESTIGATING HEALTH CARE FRAUD.

A. Systemic Changes

1. Credential and Entry Requirements for all Health Care Providers.

No insurer: Medicare, Medicaid, or private insurers, should contract with a provider to reimburse for services rendered unless the provider is licensed by a reliable organization. Currently, few states require licensing for providers such as home health care agencies, durable medical equipment companies or a number of free standing providers. This licensing should be contingent upon appropriate professional credentials and proof of financial stability. The most signficant step HCFA could take in preventing fraud in the Medicare program is to require satisfaction of meaningful licensing criteria for any provider seeking to participate in the Medicare program.

2. Training of Prosecutors and Investigative Agents.

Almost every U. S. Attorney's office now has at least one health care fraud specialist. Forty-seven states have units within the state's Attorney General's office devoted to detecting and investigating health care fraud. The FBI and HHS are increasing the number of agents and auditors devoted to health care fraud. Care should be taken to train these specialists to ensure that public resources are used wisely and appropriate cases are pursued. My experience as a prosecutor and since entering academia has confirmed that health care fraud is unlike any other white collar crime primarily because it is far more difficult to determine, until well into the investigation, whether there is fraud, or a misunderstanding because of complex or poorly worded regulations.

The case of Naveed A. Siddiqi exemplifies the difficulty these cases can pose and their consequences for the provider, the provider's patients, and the public.[164] Dr. Siddiqi is an oncologist who practices medicine in New York. He is board certified in oncology, hematology and internal medicine.[165] In 1989, HHS began an investigation of Dr. Siddiqi for what would appear, at first glance, to be blatant fraud. Dr. Siddiqi billed Medicare for "supervising the administration of chemotherapy" for two of his patients when he was out of the country. In 1990, Dr. Siddiqi was indicted on 77 counts of fraud relating to his Medicare billing practices in 1988 and 1989. In 1991,

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[164]United States v. Siddiqi, 98 F.3d 1427 (2d Cir. 1996)The author of this written statement served as a consultant to Ross, Dixon and Masback which represented Dr. Siddiqi in a matter related to his conviction.

[165]*Id.* at 1428.

he was acquitted on all but five counts - those pertaining to the supervision of chemotherapy to his two patients when he was out of town.

Upon conviction, Dr. Siddiqi was given three years probation, a $2,000 fine, ordered to serve 1,000 hours of community service and ordered to pay $640.88 in restitution, the amount at issue in the counts on which he was convicted. After conviction, Dr. Siddiqi was called before the medical licensure board of New York. He successfully defended his license, receiving a reprimand. Dr. Siddiqi was, however, excluded from participating in Medicare and Medicaid, which closed his practice. Prior to his indictment, Dr. Siddiqi's annual income from his practice was approximately $825,000 per year. After his conviction and exclusion, he was able to practice at a Veteran's Administration Hospital, at one-tenth of his former income. During its investigation of Dr. Siddiqi, HHS had impounded $150,000 in payments due but not yet paid to Dr. Siddiqi.

In 1996, the United States Court of Appeals for the Second Circuit granted Dr. Siddiqi's habeas corpus petition, vacating his conviction. Dr. Siddiqi's exclusion was due to expire a few months later. The $150,000 of impounded payments was returned to Dr. Siddiqi without interest. Dr. Siddiqi is currently attempting to regain this interest, as well as the $640 he paid in restitution. Dr. Siddiqi was 54 years old upon his conviction; 59 years old when his conviction was vacated.

In vacating his sentence, the Second Circuit held that Dr. Siddiqi's prosecution was a "miscarriage of justice" caused by a misunderstanding of the billing regulations on the part of the government. Characterizing the trial as an "ambush," the Second Circuit explained:

> Here we face a situation in which subsequent events compellingly demonstrate that a conviction had no legitimate factual or legal basis and that, but for the conduct of the prosecution in adopting shifting and at times misleading positions, no conviction would have been obtained or successfully defended on appeal.....We are firmly convinced that Siddiqi's trial and post-trial proceedings did not meet rudimentary demands of fair procedure and that the defects in his conviction are so fundamental as to constitute a miscarriage of justice.[166]

The lengthy opinion discussed the trial and post trial proceedings in detail, outlining the various theories which the prosecution gave throughout as to why Dr. Siddiqi's conduct was a crime. The crux of the case was whether Dr. Siddiqi performed the service described by the billing code, "96500," which he listed on Medicare claim forms. According to the Carrier Manual, this code covered "chemotherapy injection ... administered by assistant under supervision of physician or by physician."[167] The prosecutor, or case agent when testifying as a witness, variously explained that

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[166] *Id.* at 1440.

[167] *Id.* at 1429.

Dr. Siddiqi billed for services not provided since he did not "administer the chemotherapy";[168] that Dr. Siddiqi falsely claimed that he administered the chemotherapy;[169] that Dr. Siddiqi did not "supervise" the administration of chemotherapy;[170] that Dr. Siddiqi falsely claimed to have supervised the administration of the chemotherapy, since he failed to provide for another physician to "cover" for him while he was out of town.[171]

In fact, there was evidence from eight different sources as to what was required for an oncologist to bill for supervising chemotherapy under code 96500. These sources included pronouncements by a professional society, the American Society of Clinical Oncologists; Medicare Bulletins published by HCFA and distributed to providers; internal memoranda within HCFA; federal statutes and regulations promulgated by HHS; legislative history; the Carrier Manual; consultants in oncology. These sources indicated that the billing instructions were confusing; that Dr. Siddiqi's use of the 96500 code was the best code for the service he performed; and that it was customary within the profession to use this code to bill for the service Dr. Siddiqi performed.[172] There was evidence at trial that Dr. Siddiqi "supervised" the administration of the chemotherapy by examining the patients and prescribing the dosage of chemotherapy they were to receive, and by arranging for coverage by another physician and leaving instructions about the patients with the covering physician while he was away.[173] The Second Circuit noted that in this case "billing under that code [96500] is at worst an attempt to bill at the outer limits permitted, not fraud....It may well be that arranging for coverage-- a common practice among physicians-- is billable under code 96500...."[174]

The experience of Dr. Siddiqi is every health care provider's nightmare: ambiguous billing regulations; a prosecutor and case agent who do not understand the case; conviction; exclusion; ruination of a career; financial devastation. Although it is commendable that Congress, the states and private insurers have recognized the seriousness of health care fraud and committed serious resources to fighting this fraud, it wastes public resources, cheapens the American justice system and devastates lives to rush into this area without skill and experience. As the *Siddiqi* case shows, serious consideration should be given to the training being provided to the new prosecutors and

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[168]*Id.* at 1428.

[169]*Id.* at 1429.

[170]*Id.* at 1429.

[171]*Id.* at 1430.

[172]Review by author of documents gathered in representation of Dr. Siddiqi by Ross, Dixon and Masback.

[173]*Id.* at 1430-32.

[174]*Id.* at 1439.

agents being hired to pursue health care fraud.

3. Standardize billing instructions.

Health care providers are subject to multiple, diverse and often changing instructions on how to bill. As noted in the discussion of *United States v. Siddiqi*, in II(B), *supra*, for example, there were eight sources of interpretation as to one billing code. Such confusion makes it difficult for scrupulous providers to bill correctly, casts a net so wide that it snares honest providers, and makes it difficult to prosecute the unscrupulous provider who can credibly claim mistake when in fact she intended fraud. HCFA should standardize all billing codes for all Medicare and Medicaid providers and ensure that carriers/intermediaries communicate more effectively with providers about billing information.

B. Privatizing Detection and Proof of Fraud.

1. Separating fraud detection duties from claims processing duties contracted to carriers/intermediaries.

Leaving fraud detection to carriers/intermediaries is allowing the fox to guard the hen house. As discussed in I(F), *supra*, carriers and intermediaries are inappropriate entities to monitor the fraud, waste and abuse that is taking place in Medicare and Medicaid. Detecting fraud is inconsistent with prompt processing of claims - the major contractual duty assumed by carriers/intermediaries. In addition, the temptation and opportunity is present to conceal inadequate efforts at detecting fraud, as well as the fraud itself. For the same reasons, outside contractors should be given the duty of reviewing work of managed care organizations hired by Medicare.

2. Amend the False Claims Act to preclude government employees whose duty it is to investigate fraud from qualifying as qui tam relators as to fraud uncovered as part of their official duties.

The False Claims Act lists certain individuals who are ineligible to serve as qui tam relators. Government employees are not included in this list. Primarily for this reason, the courts addressing the issue of whether government employees qualify as qui tam relators have held that they do.[175] While some of these courts acknowledge the public policy difficulties created when

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[175] *First Circuit:* United States *ex rel.* LeBlanc v. Raytheon, 913 F.2d 17, 20 (1st Cir. 1990), *cert. denied* 499 U.S. 921 (1991);

Fourth Circuit: Erickson v. Am. Inst. of Bio. Sciences, 716 F. Supp. 908, 912-18 (E.D.Va.1989);

Tenth Circuit: United States *ex rel.* Fine v. MK-Ferguson Co., 861 F. Supp. 1544, 1549 (D.N.M. 1994).

government employees serve as qui tam realtors[176] other courts reason that allowing government employees to serve as qui tam plaintiffs furthers one of the goals of the 1986 amendments reviving the FCA: motivating individuals to serve "as a check that the Government does not neglect evidence, cause unduly [sic] delay, or drop the false claims case without legitimate reason.[177]

There are, however, significant public policy problems in allowing government employees to serve as qui tam relators: government investigations may be prematurely disclosed or otherwise compromised; races to the courthouse may be encouraged as the government employee strives to beat the Attorney General in filing the lawsuit; a government employee's duty, as an employee, includes reporting fraud to the government, not profiting personally from such fraud through private litigation.[178] There are also potentially serious ethical conflicts that may arise if government employees are allowed to reap huge bounties simply by fulfilling their employment responsibilities.[179] Such bounties could have the unfortunate effect of encouraging government fraud investigators *not* to report fraud they discover during the course of their employment so they can use it themselves to file a qui tam lawsuit.[180] Because of these problems, Congress should amend the False Claims Act to exclude government employees from qualifying as qui tam relators as to fraud uncovered as part of their official duties.[181]

2. Amend RICO to include the recent health care fraud offenses as "racketeering activity."

Although mail fraud and wire fraud are predicate acts under RICO and may well cover all species of health care fraud, there may be some exceptions. In addition, by ensuring that all of the health care fraud offenses created by HIPAA are included in RICO as "racketeering activity," class actions alleging health care fraud will be able to proceed. Currently, civil RICO is

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[176]*Williams*, 931 F.2d at 1503.

[177]United States v. CAC - Ramsay, Inc., 744 F. Supp. 1158, 1160 (S.D. Ga. 1990) (citing S. Rep. 347 at 5290-91).

[178]Although the Eleventh Circuit held that government employees were eligible to serve as qui tam plaintiffs, the court noted public policy problems created by such a ruling. The Eleventh Circuit stated that it based its ruling on the statutory language which it found permitted government employees to serve as qui tam plaintiffs. The Eleventh Circuit opined that if the Congress wanted to prohibit government employees from serving as qui tam plaintiffs, it should amend the statute. *Williams*, 931 F.2d at 1502.

[179]*Fine*, 821 F. Supp. at 1361.

[180]*Fine*, 821 F. Supp. at 1361. *Id.*

[181]Compare, United States *ex rel.* Fine v. MK-Ferguson Co., 861 F. Supp. 1544, 1549 (D.N.M. 1994) (making this suggestion).

one of the few avenues permitting such class actions.

C. Avoid Overcriminalization

1. Decriminalize the anti-kickback statute except with regard to physicians.

As discussed in I(D), *supra*, the anti-kickback statute is a crime, punishable by five years imprisonment, as well as a civil cause of action and grounds for administrative sanctions of civil monetary penalties and exclusion. Violations of Stark I and II are not crimes, only grounds for civil and administrative sanctions.

Also, as discussed in I(D), there are dangers to overcriminalizing behavior, especially behavior acknowledged as legitimate, shrewd and practiced widely in other businesses. Only when a physician is the payer or recipient of a kickback is there potential for the harm the anti-kickback statute is aimed at—tainting the provider's independent medical judgment. In other instances, the kickback affects, at most, "steerage": where the medical referral where go, not whether it will be artificially generated. For these reasons, criminal prosecutions under the anti-kickback statute should be reserved for situations where medical judgment is jeopardized.

2. Require DOJ approval prior to opening an investigation on a publicly traded company.

This suggestion would apply to any white collar investigation. As shown by the impact on the price of Columbia/HCA stock, merely opening an investigation can dramatically affect a public company when the news of the investigation becomes public. While investigations of public companies may well be warranted, standardizing the review prior to opening an investigation, much as is done in RICO cases prior to indictment or with grand jury subpoenas to attorneys, would help to prevent unnecessary disruptions to on going businesses.

3. Promulgate a Reasonable Standard for Corporate Criminal Liability in American Law.

Lawmakers as well as the many health care providers which operate in corporate form may find it surprising how easily corporations incur criminal liability in the United States. The consequences of conviction are severe: forfeiture of assets, fines up to $7.5 million,[182] court-supervision of day to day operations,[183] possible loss of corporate charter.

American law currently uses two standards to determine when a corporation should be held criminally liable. Both impose vicarious liability by transferring the criminal acts and intent of

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[182]U.S. Sentencing Comm'n, *Guidelines Manual*, Chapter 8 [hereinafter U.S.S.G.].

[183]U.S.S.G. § 8D1.4.

corporate agents to the corporation. The traditional or respondeat superior standard is used in the federal courts and adopted by some state courts. Derived from agency principles in tort law, it provides that a corporation "may be held criminally liable for the acts of any of its agent [who] (1) commit a crime, (2) within the scope of employment, (3) with the intent to benefit the corporation."[184]

The American Law Institute's Model Penal Code (MPC) provides the major alternative standard for corporate criminal liability. The MPC provides that a corporation is criminally liable if the criminal conduct was "authorized, requested, commanded, performed or recklessly tolerated by the board of directors or by a high managerial agent acting in behalf of the corporation within the scope of his office or employment."[185] Thus, the MPC standard also employs a respondeat superior model, but in a limited fashion: a corporation is liable for conduct of only *some* agents (directors, officers, and high echelon corporate employees).

If courts strictly enforced the requirements that the action be within the scope of the corporate agent's employment and undertaken with intent to benefit the corporation, corporate criminal liability would be narrower. Rarely will criminal acts be within an individual's scope of employment and, it is difficult to see how such conduct "benefits the corporation." However, as construed by courts, these two requirements are almost nonexistent. Courts deem criminal behavior to be "within the scope of employment" even if the conduct was specifically forbidden by corporate policy. Courts also find conduct to be undertaken "with the intent to benefit the corporation" when the corporation received no benefit and no one within the corporation knew of the criminal conduct when it occurred.[186]

United States v. Hilton Hotels Corp.,[187] provides an example. The purchasing agent at a Hilton hotel in Portland, Oregon, threatened a supplier of goods with the loss of the hotel's business if the supplier did not contribute to an association that was formed to attract conventions to

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[184]"Developments in the Law—Corporate Crime: Regulating Corporate Behavior Through Criminal Sanctions," 92 Harv. L. Rev. 1227, 1247 (1979). Commonwealth v. Beneficial Finance Co., 275 N.E.2d 33 (Mass. 1971), exemplifies this approach.

[185]American Law Institute, Model Penal Code § 2.07(1)(c) (Proposed Official Draft 1962).

[186]*Third Circuit:* United States v. American Radiator & Standard Sanitary Corp., 433 F.2d 174, 204 (3d Cir. 1970), *cert. denied* 401 U.S. 948 (1971); United States v. Armour & Co., 168 F.2d 342, 343-344 (3d Cir. 1948).

Fifth Circuit: Standard Oil Co. v. United States, 307 F.2d 120, 128 (5th Cir. 1962).

Ninth Circuit: United States v. Hilton Hotels, Inc., 467 F.2d 1000, 1002-1004 (9th C ir. 1972), *cert. denied* 409 U. S. I 1 25 (1975).

[187]United States v. Hilton Hotels Corp., 467 F.2d 1000 (9th Cir. 1972), *cert. denied* 409 U.S. 1125 (1973).

Portland.[188] The corporate president testified that such action was contrary to corporate policy.[189] Both the manager and assistant manager of the Hotel testified that they specifically told the purchasing agent not to threaten suppliers. Nevertheless, the court convicted Hilton Hotel Corporation of antitrust violations under the respondeat superior standard of liability. Critics argue that in this day of multi-national corporations with thousands, even hundreds of thousands, employees, it is unrealistic to expect that a corporation can monitor the activities of all of its agents and employees.

The MPC Standard is criticized as unworkable, unrealistic, inconsistent with tenets of criminal law and socially destructive. Requiring proof that higher echelon officials within a corporation participated in or tolerated criminal behavior assumes that the inner workings of a corporate entity are discoverable and provable. Rarely will this be the case. Although the MPC standard reigns in the absolute liability of the respondeat superior standard somewhat by holding a corporation liable for the acts of only *some* corporate agents, the MPC standard still fails to assess corporate intent. Also, by making corporate liability hinge on the knowledge or actions of higher echelon agents, the MPC standard encourages these agents to insulate themselves from illegal corporate activity.[190]

Thus, both the MPC and respondeat superior standards of corporate criminal liability fail to separate the "good" corporations that educate and encourage employees to follow the law, from the "bad" corporations that encourage illegal behavior. Employing this broad of a standard of corporate criminal liability blurs the line between criminal and civil liability; dilutes the impact of a criminal conviction; fails to give prosecutors adequate guidance as to which corporations should be prosecuted; creates an atmosphere of uncertainty for businesses; and, fails to reward responsible corporations. While corporate criminal liability should be retained, an appropriate standard for assessing it should be developed and implemented.

D. Enhance Tools for Prosecuting the Type of Fraud Likely to Occur Under Managed Care Reimbursement.

1. Require Medicare and Medicaid managed care plans to certify, annually, that they have provided all necessary services to patients within the plan, in accordance with accepted medical standards.

As noted in I(B), *supra*, there is substantial financial incentive in a managed care system to underprovide necessary services. When this is intentional, it should be prosecuted as a

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[188] *Id.*, 467 F.2d at 1002.

[189] *Id.*, 467 F.2d at 1004.

[190] Commonwealth v. Beneficial Finance Co., 360 Mass. 188, 275 N.E.2d 33, *cert. denied* 407 U.S. 914 (1972).

crime. It will greatly facilitate such prosecutions if HMOs are required to certify by specific, written statement that all necessary services have been provided to covered patients. Including such a certification would provide the basis for a prosecution when the evidence demonstrates intentional failure to provide necessary services. Notably, this would also provide a civil cause of action for private citizens under either civil RICO (with mail fraud and wire fraud as likely predicate acts) or the False Claims Act since a false certification would constitute mail fraud and a false claim under the False Claims Act.

4. Require unified billing by nursing homes and providers serving nursing home patients .

As the GAO noted in a January, 1996 report entitled, *Fraud and Abuse: Providers Target Medicare Patients in Nursing Facilities*, there are several features about nursing homes which make them easy targets for fraudulent billing by providers who service nursing home patients. First, because there are a lot of patients congregated in a nursing home, unscrupulous providers can operate a scam in volume. Second, for a variety of reasons, it is fairly easy for providers to gain access to information about patients which makes it possible to submit false claims to Medicare. Such information includes Social Security Numbers, diagnosis and treatment history, and names and other identifying data about providers who also treat the patients. Third, under HCFA's rules, providers can bill Medicare directly for services rendered to nursing home patients. There is no one, except the patient - who may be too ill or old to monitor billings, to corroborate that services were provided or needed.

Requiring that all billings by all providers for all services rendered to nursing home patients go through the nursing home, where the nursing home pays the providers upon receipt of payment, would institute a system for reviewing claims. Granted, this type of unified billing would impose the burden on nursing homes to analyze the accuracy of claims of individual providers for services rendered to nursing home patients. However, this additional responsibility could be included in the certification process for nursing homes; the per diem payment to nursing homes could be increased to cover any additional cost (the savings from deterring and detecting fraud should more than outweigh the additional cost); and, as noted in I(G) above, there is developing a cadre of specialists who can provide this service to nursing homes.

STATEMENT OF

BRUCE C. VLADECK
ADMINISTRATOR

HEALTH CARE FINANCING ADMINISTRATION

ON

"PREVALENCE OF HEALTH CARE FRAUD AND ABUSE"

SENATE COMMITTEE ON GOVERNMENT AFFAIRS
PERMANENT SUBCOMMITTEE ON INVESTIGATIONS

JUNE 26, 1997

INTRODUCTION

Mr. Chairman and Members of the Subcommittee, I am very pleased to have this opportunity to describe the Health Care Financing Administration's programs to fight fraud and abuse in Medicare and Medicaid. As we stand on the threshold of the twenty-first century, we are faced with the formidable task of ensuring the solvency of the Trust Fund, and preserving Medicare for future generations. In order to do this, we must begin by making sure that every dollar we spend for our beneficiaries is well-spent, and that our goals of efficiency and cost-effectiveness do not compromise the quality of their health care.

Why We Need to Pay Right the First Time

The annals of medicine are replete with case histories demonstrating that prevention is the best antidote to illness. This is equally true in the area of fiscal well-being: in order for our Medicare and Medicaid programs to remain both solvent and strong, we need to prevent improper or fraudulent claims which strain the fiscal and personnel resources of the system. By guaranteeing the initial accuracy of both claims and payments, we avoid having to "pay and chase," and we can prevent opportunities for fraud and abuse.

Incorrectly billed claims can stem not only from fraud, but from confusion and misinformation about the proper billing procedures. For example, if there is a payer primary to Medicare, the Medicare contractor will reject the claim and submit it to the appropriate primary payer. Where Medicare is primary, the Medicare contractor will make payment, then send the paid claims data to the supplemental insurer. HCFA uses many pre-payment mechanisms to determine the primary payer for benefits for a Medicare beneficiary and to ensure Medicare pays in the right order of payers. These mechanisms are part of our Medicare as a Secondary Payer (MSP) Activity, which I will describe in detail later in this testimony. Currently, we are seeking legislation that would improve our ability to verify whether Medicare is the primary or secondary payer.

OVERVIEW: THE ISSUES

The sheer complexity of the health care delivery system virtually guarantees that there will be instances of unscrupulous claims billing. While some high-profile examples of fraud and waste are well-known to the public because of media attention, there are many less visible areas of concern. Some of these include:

• **Abusive Billing in Nursing Homes** — Aside from the typical kind of fraud that occurs in charging patients for services they have not received, there are other, more difficult-to-detect abuses to which beneficiaries of nursing homes are vulnerable. These include inappropriate designation of nursing home patients as hospice patients, false patient census reports, improper billing of supplies and services for patients eligible for both Medicare and Medicaid ("dual eligibles"), unnecessary or inappropriate services being prescribed for nursing home patients, and billing as therapy services for services paid in the nursing home rate. Unnecessary medical supplies may be ordered for the

unsuspecting patient, such as several cases found by the DHHS Inspector General (IG), in which thousands of dollars of surgical tape, hydrogel wound filler, and orthotic devices were inappropriately ordered and made available to other patients. Also, it has been estimated that as much as 32% of mental health services ordered for Medicare nursing home residents were unnecessary or inappropriate. Part of the problem stems from the fact that the nursing home itself is not responsible to coordinate the services, which may be initiated and billed by an outside entity.

• **Home Health Fraud** — The "invisibility" of the home health setting invites profiteers to prey on disabled and elderly patients who may often be isolated, uninformed, and lacking the support of friends or family. We are finding continuous problems with unnecessary home health services, especially those provided to beneficiaries who are not homebound. Because of the difficulty in monitoring these situations, the patient may be at the mercy of an unethical provider or supplier. Over-prescription and overcharging of oxygen and tube feeding supplies for home health patients have been found in bills submitted to Medicare and Medicaid. Through HCFA's Operation Restore Trust (ORT), we have located and penalized fraudulent home health agency owners across the Nation, and saved millions of dollars.

The 1981 report issued by the Senate's Permanent Subcommittee on Investigations identified several areas of Medicare and Medicaid home health care needing better oversight, and recommended that HCFA notify home health intermediaries in a timely fashion of any regulatory changes. We have acted on this recommendation, and we have developed checks and balances that ensure that this is done. Current HCFA procedures require that intermediaries have at least 90 days to carry out any program actions that may be required of them. Therefore, any legislative/statutory, regulatory, policy, or electronic system *changes that directly affect the contractors* are published in a quarterly release of HCFA's Task Management Plan, which is then distributed, along with pertinent materials, to intermediaries with a minimum 90 days' implementation deadline. This process alerts intermediaries that they must notify providers of new or revised program procedures or requirements. Intermediaries are also required to communicate program changes to their providers in a communique, usually in the form of a bulletin or similar form of notification. These checks and balances ensure accountability --- of both intermediaries and HCFA.

• **Durable Medical Equipment** --- There is widespread concern that Medicare's payments for durable medical equipment are excessive. Medicare payments for DME are based on a fee schedule methodology established by Congress in Omnibus Budget Reconciliation Act (OBRA) 1987, and these fee schedule amounts were based on supplier's "reasonable charges" in the mid-1980s. Unless otherwise specified by Congress, these amounts have been increased annually by the Consumer Price Index-Urban (CPI-U) as required by statute. This statutorily prescribed payment methodology does not consider changes in technology or any other factors impacting suppliers' costs and as a result HCFA's payments for DME are often excessive.

Problems with the durable medical equipment (DME) industry have resulted in stricter controls over who can apply for, and receive, a license as a DME provider. A Notice will be issued this summer by HCFA that will require that DME providers meet certain criteria, including putting up a surety bond for licensure, and greater proof of the bona fide existence of the business. This will prevent

abuses such as the case of the Florida man who received a DME license, despite the fact that the only actual supplies he had in stock were stuffed alligator heads and other souvenirs he sold from his garage. He had applied for a DME certification to sell wheelchairs to complement his brother-in-law's business of installing wheelchair lifts in cars. Examples like this are a good argument for DME bonding.

• **Fraudulent Billing Practices** --- Complex claims billing procedures offer multiple ways of cheating the system, from overt inflation and exaggeration of the level of services provided ("upcoding") to blatantly false cost reports submitted for reimbursement. A Maryland nursing home operator was prosecuted for adding his personal entertaining and decorating expenses to the facility's Medicaid bill, including a charge for services rendered by the operator's relative who was actually in jail at the time. In another case reported by the GAO, a supplier for a long-term care facility was forging physicians' signatures on certificates of medical necessity, and then billing for items that were either unnecessary, had already been provided to the patient, or were in fact never delivered. The President's FY98 Budget includes provisions to develop prospective payment systems for several services in Medicare. PPS pays a set rate according to the characteristics of the patient, and removes many of the incentives for providers to provide excessive services or submit fraudulent cost reports to receive high reimbursement.

• **Kickbacks** --- Providers such as laboratories, ambulance companies, and pharmacies may enter into unethical agreements with nursing home owners and clinical psychologists that may include kickbacks in exchange for being allowed to provide services to the nursing home residents. HCFA's State Medicaid Fraud Control Units have found cases of nursing home owners authorizing unnecessary services because they receive kickbacks from these ancillary services, such as ambulance companies, and laboratory and therapy services.

• **3-Day Payment Window** --- Current law prohibits providers from billing for pre-admission outpatient tests and services performed within 3 days of the time a patient is admitted to a hospital, if the tests and services are diagnostic services or other services related to the admission. This precludes the potential for double-billing medical services which should properly be provided as part of inpatient services. This 3-day payment window applies only to hospitals under the prospective payment system, since 1994 SSA legislation reduced the window to 1 day for non-PPS hospitals. Most improper billing relating to pre-admission services results from a misunderstanding of the law, which was originally instituted to curb further "unbundling" of services, i.e., separating of the various pre-admission tests in order to obtain additional payments.

• **Inpatient Mental Health Services** - As the occupancy rates of psychiatric hospital inpatient beds have dropped, many hospitals have attempted to find ways to fill the void, often by hospitalizing patients who should be cared for in other, non-psychiatric, facilities. This is a temptation because diagnostic-related groups (DRGs) are not imposed on care in psychiatric hospitals, as they are in short-term acute care hospitals. Hospitalization of patients in psychiatric facilities can be extremely lucrative, with charges as high as $1000 per day. Also, patients hospitalized in psychiatric facilities are sometimes billed for unnecessary and unordered services. The President's FY98 budget has a provision to make Medicare payments less lucrative for these situations; ceilings would be established

on reimbursements, so that facilities could not be reimbursed for these costs, if they were much more expensive than other psychiatric hospitals.

This is a particular area of concern for HCFA because of the potential for coercive hospitalization under some State laws, such as a case recently reported in Massachusetts. A child who had been taken to a hospital for a medication adjustment for his epilepsy was forcibly hospitalized, against his parents' wishes, in a psychiatric hospital. Although this situation was due in part to Section 12 of Massachusetts State law, it raises disturbing questions about lack of oversight in psychiatric hospitalizations.

• **Marketing Abuses** - Questionable sales techniques are sometimes used in the marketing of health insurance, especially when the potential customers are elderly and may be ill-equipped to make informed choices. Some marketing representatives may use fear tactics to persuade beneficiaries to sign up for benefits they don't need and can sometimes ill afford. In response to these abuses, HCFA will be issuing National Managed Care Marketing Guidelines this summer, to assure that marketing materials present balanced and accurate information to beneficiaries and to discourage fraudulent or deceptive representation of health plans or services.

HCFA'S CURRENT INITIATIVES AGAINST FRAUD AND ABUSE

This Administration is seriously committed to aggressively prosecuting and preventing all forms of waste, fraud, and abuse. Toward this goal, we worked on a bi-partisan basis with the Congress to develop the necessary legislation. The Health Insurance Portability and Accountability Act of 1996 (HIPAA), which was enacted last year, contained important provisions to aid us in our war on waste, fraud and abuse in the Medicare program. Two of the most significant provisions for the Health Care Financing Administration (HCFA) were the implementation of the Medicare Integrity Program (MIP) and the Fraud and Abuse Control Program.

Medicare Integrity Program (MIP)

This program authorizes the Secretary to promote the integrity of the Medicare program by entering into contracts with eligible entities to carry out program integrity activities such as audits of cost reports, medical and utilization review, and payment determinations. MIP provided a stable source of funding for HCFA's program integrity activities, and provided us with the authority to contract for these activities with any qualified entity, *not* just those insurance companies who are currently our fiscal intermediaries or carriers.

The Medicare Integrity Program (MIP) was enacted to strengthen the Secretary's ability to deter fraud and abuse in the Medicare program in a number of ways. First, it created a separate and stable long-term funding mechanism for program integrity activities. Historically, Medicare contractor budgets had been subject to fluctuations of funding levels from year to year. Such variations in funding did not have anything to do with the underlying requirements for program integrity activities. This instability made it difficult for HCFA to invest in innovative strategies to control fraud and

abuse. Our contractors also found it difficult to attract, train, and retain qualified professional staff, including clinicians, auditors, and fraud investigators. A dependable funding source allows HCFA the flexibility to invest in new and innovative strategies to combat fraud and abuse. It will help HCFA shift emphasis from post-payment recoveries on fraudulent claims to pre-payment strategies designed to ensure that more claims are paid correctly the first time.

Second, by permitting the Secretary to use full and open competition rather than requiring that we contract only with the existing intermediaries and carriers to perform MIP functions, the government can seek to obtain the best value for its contracted services. Prior law limited the pool of contractors that could compete for contracts, thus, we were not always able to negotiate the best deal for the government or take advantage of new ways to deter fraud and abuse. Using competitive procedures, as established in the Federal Acquisition Regulations System (FARS), we expect to attract a variety of offerors who will propose innovative approaches to implement MIP.

Third, MIP permits HCFA to address potential conflict of interest situations. We will require our contractors to report situations which may constitute conflicts of interest, thus minimizing the number of instances where there is either an actual, or an apparent, conflict of interest. By invoking the FAR in establishing multi-year contracts with an expanded pool of contractors, we will be able to avoid potential conflicts of interest and obtain the best value. Also, by permitting us to develop methods to identify, evaluate and resolve conflicts of interest, we can create a process to ensure objectivity and impartiality when dealing with our contractors. This is a concern particularly when intermediaries and carriers are also private health insurance companies processing Medicare claims.

To ensure that our resources are used as wisely as possible, we will also gradually reduce the number of contractors performing payment safeguard activities. Prior to the passage of HIPAA, all 72 contractors performed all aspects of program integrity work. With highly specialized contractors focusing solely on fraud and abuse prevention and detection, we will gain a cost-effective and efficient pool of contractors. We plan to focus contractors on program integrity activities for a geographic area, rather than by provider type, as is current practice. That way, contractors will have a more comprehensive picture of activity, and will be able to monitor whether doctor bills match hospital bills, in terms of procedures performed and dates of service. Furthermore, the reduction in the number of contractors performing activities such as medical and fraud review as well as audit does not mean that local presence will be eliminated. Medical directors will continue to play an important role in benefit integrity activities, and we intend to retain locally-based Medical directors as well as to continue our relationship with local physicians by using groups like Carrier Advisory Committees.

We are currently developing regulations to implement MIP, and we are also working on a scope of work for competitive contracts. As we transition work from one of our contractors, Aetna (which is terminating its Medicare work), we are testing a new contracting relationship in several Western States that will separate out (and consolidate) payment integrity activities from claims processing. This will give us valuable experience as we prepare to implement MIP.

Operation Restore Trust (ORT)

The Operation Restore Trust (ORT) project was the first comprehensive effort at collaboration between HCFA and law enforcement agencies. This two-year demonstration project, which was launched by the President in May 1995 and concluded on March 31, 1997, was designed to demonstrate new partnerships and new approaches in finding and minimizing fraud in Medicare and Medicaid. As a demonstration project, ORT targeted four areas of high spending growth: home health agencies, nursing homes, DME suppliers, and hospices. Since more than a third of all Medicare and Medicaid beneficiaries are located in New York, Florida, Illinois, Texas, and California, ORT efforts were targeted at these five states.

Fraud and Abuse Control Program

The program integrity activities of the Medicare contractors initiate many of the cases subsequently developed by the Office of Inspector General and Federal Bureau of Investigation, and support their prosecution by the Department of Justice. Using monies made available through the Fraud and Abuse Control Fund, established in HIPAA, we expanded our successful ORT efforts using the State survey agencies to be our "eyes and ears" in the field and to report back to the contractors whether providers are meeting Medicare billing as well as quality requirements. We have used this model successfully with our expanded home health surveys in the 5 Operation Restore Trust (ORT) States.

Through HCFA's expanded efforts, approximately $1.8 million has been allocated to HCFA for "Project ORT" through HIPAA's Fraud and Abuse Control Program, to enhance the program integrity activities that involve collaboration with State certification agencies. Eighteen States will participate in a total of 26 HIPAA funded projects, allowing us to survey approximately 300 providers for both certification and reimbursement issues. These enhanced surveys will be made of providers of home health services, skilled nursing services, outpatient physical therapy services, and laboratory services, as well as psychiatric services in both hospitals and community mental health centers. Many of these surveys will be modeled after the home health agency and skilled nursing facility surveys conducted during ORT. This collaboration, which is being institutionalized through the Fraud and Abuse Control Program established in HIPAA, establishes a funding stream for health care fraud and abuse activities, and requires DoJ and HHS to establish priorities jointly.

Medicare as a Second Payer (MSP)

This "front end" activity takes a proactive approach to identifying the correct payer before the claim is processed, so that Medicare does not pay inappropriately or unnecessarily. There are multiple areas that are scrutinized to ensure that the appropriate payer is billed:

Initial Enrollment Questionnaire (IEQ) - The IEQ is used to gather Medicare Secondary Payer (MSP) information for most new beneficiaries approximately three months before they become entitled to Medicare. For beneficiaries who do not apply for Medicare entitlement until after becoming eligible, HCFA conducts MSP development at the time the Medicare application is filed. This function is currently performed by an independent contractor.

First Claim Development - For all claims, the individual completing the Medicare claim for payment should indicate if there is other insurance that is primary to Medicare. If the beneficiary has not responded to the IEQ, and MSP information is not included on the first claim submitted for that beneficiary, the Medicare contractor submitting the first claim is responsible for mailing a questionnaire to the beneficiary or the provider to gather the required information. This function is currently performed by all Medicare fiscal intermediaries (FIs) and carriers.

Trauma Code Development - When a claim is received for Medicare primary payment and the claim contains one of certain specific trauma codes (which could indicate Worker's Compensation, automobile accidents, or other liability situations), the claim is scrutinized to determine if another insurer is the correct primary payer. Currently, this function is performed by the Medicare FIs and carriers.

MSP Litigation Settlement - HCFA has entered into agreements to settle MSP litigation with several health insurance companies. As part of these settlements, the affected private health care plans are required to periodically submit MSP information on their enrollees to HCFA. This activity is estimated to result in additional $540 million in MSP savings for Fiscal Year 1997. The settlement agreements require this mandatory reporting for 5 years. GHI, a Medicare Part B carrier, is currently processing this information to the Common Working File (CWF).

Internal Revenue Service (IRS)/Social Security Administration (SSA)/HCFA Data Match - Information on employers and employees provided by the IRS and SSA is analyzed by HCFA for use in contacting employers concerning possible insurance coverage of Medicare beneficiaries.

Voluntary Insurer/Employer Reporting for MSP - As an alternative to responding to the IRS/SSA/HCFA data match employer questionnaires, employers may enter into a voluntary agreement with HCFA to report primary payer information on a current basis. Likewise, other health insurance companies are encouraged to report on their insured who are Medicare eligible on a current basis. HCFA Central Office is currently negotiating its first such voluntary agreement.

Hospital Admissions Procedures Review - Institutional providers such as hospitals, as part of their Medicare participation agreements, are required to conduct admissions interviews to determine if another primary payer exists. FIs are required to review a sample of their hospitals annually to determine if their admissions procedures are complete and are routinely followed. MSP information thus acquired during hospital intake ensures that Medicare pays in the appropriate order of financial liability.

Claims Submission - Medicare claims submission instructions require that the existence of a primary payer other than Medicare be indicated on the claim. This information is also checked with HCFA's own insurance information obtained from other sources.

DATA SYSTEMS TO FIGHT FRAUD AND ABUSE

Single Integrated Database System - HCFA is in the process of developing an automated Medicare claims processing and information system, which will, among other things, assist in our program integrity and provider exclusion efforts. This integrated system is being designed to consolidate the currently fragmented Medicare claims processing into one standardized system. Although we are currently re-examining the specific implementation strategy for this system, we believe a fully operational integrated system will assist us in preventing fraud. A significant advancement for HCFA will be the use of advanced technology to detect fraud and abuse at the outset -- before Medicare pays health care providers. The single system will facilitate identification of data files containing aberrant patterns and data discrepancies, and alert Medicare contractors to review more cautiously selected Medicare claims.

Full implementation of an integrated database will aid us in preventing fraud and abuse because it will greatly improve HCFA's ability to profile data on a National or regional basis by type of service. We plan to use these profiles to identify and review aberrant billing patterns and to prevent inappropriate claims from being paid in the first place, thus avoiding the need to chase down those fraudulent claims that have already been paid. The single system will integrate data from Medicare Part A, Part B, and managed care and provide the opportunity to have a comprehensive view of billing practices and to incorporate new technology to facilitate innovative investigative techniques. We plan to use artificial intelligence in an analysis of patterns of care, auto-adjudication, and other analytic tools that will permit improved identification of payments that should not be made -- prior to payment.

One way in which the new system will provide an enhanced ability to fight fraud is through the use of the National Provider Identifier, which is an industry wide unique identifier for providers and suppliers created under the authority of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). This identifier will be used to create an integrated database that will contain a record of all providers and suppliers who are certified to bill Medicare for medical supplies or equipment provided to our beneficiaries. The integrated database will contain a record of all providers and suppliers who are certified to bill Medicare for medical services or equipment provided to our beneficiaries. Our legislative proposal for authorization to require social security numbers from Medicare providers will enhance our ability to identify fraudulent providers and keep them from further defrauding the program. If a provider is excluded from the Medicare program, or has been identified as fraudulent, that provider will be flagged in the database, which must be accessed before the claim is paid. A single system will also enable us to flag providers who are excluded from Medicaid and other Federal health programs as well.

An integrated information system will improve our ability to assure proper payment. When a bill or claim is entered into the database from an excluded provider or supplier, payment will be denied. Additionally, the OIG can develop a civil monetary penalty case tracking system, which will use the claim submission information from the database to assist in identifying excluded providers and ensuring that they do not continue to bill.

HCIS Database - An important building block for HCFA's integrated information system is the HCFA Customer Information System (HCIS). This database supports multiple capabilities including program integrity initiatives, evaluation of policy and procedural changes, medical review studies, and dissemination of customer information. HCIS allows the user to view provider or service utilization data initially at the National level, and subsequently "drill down" through the various levels, from the State, contractor, provider type, or individual provider, to the beneficiary. This capability allows the rapid identification and analysis of factors contributing to aberrant data. As a result, audits or reviews can be focused, rapidly and inexpensively, on a particular level.

HCIS is currently limited to inpatient hospitals, outpatient providers, home health agencies, hospices, skilled nursing facilities and physicians. By the end of fiscal year 1997, these provider types will be augmented by DME suppliers and clinical laboratories. We are also planning to incorporate additional program data, such as cost report and enrollment data.

Los Alamos National Laboratories - In September 1996, HCFA signed an interagency agreement with the Los Alamos National Laboratory (LANL) to develop mathematical models which identify potentially fraudulent and abusive patterns. The agreement, which arose out of Operation Restore Trust, is for the two-year period, FY96 through FY97. Its purpose is to provide analytical and computer support to develop improved approaches to operating the Medicare program. The ultimate goal is the development of prepayment software to detect and deter fraudulent and improper claims. To date, LANL has made considerable progress. By the end of 1998, we will be able to better assess if their initial work with specific beneficiary and provider populations can be repeated and applied more broadly to other beneficiary and provider populations. LANL is also exploring new ways their technology can assist in our fight against Medicare fraud and abuse. Within the next few months, they will submit for our consideration a proposal for future fraud detection work. LANL is also under contract with HCFA to determine when the contractors and the computer systems should transition into the integrated database environment.

Fraud Investigation Database - One of HCFA's most promising initiatives in excluding fraudulent providers is the Fraud Investigation Database (FID). We began implementing the FID in May 1996, and we have been pleased with the success of the system. The FID is a case-tracking system to record and disseminate information regarding exclusions, and contains extensive national Medicare and Medicaid fraud data as well as comprehensive information on all excluded providers. The database is intended to assist HCFA and our partners in identifying excluded providers, as well as those who are allegedly defrauding the programs. For example, a Medicare contractor in one area can use this information to ensure that the providers it is reimbursing have not been excluded through the actions of another contractor.

In an effort to enhance coordination of the exclusion process, the FID is also accessible to the Medicaid anti-fraud agencies such as the Medicaid Fraud Control Units and the Surveillance and Utilization Review Systems. We expect very soon to be able to obtain data from these Medicaid entities on cases and information related to the providers that they suspect to be fraudulent. The FID is also designed to ensure the coordination of anti-fraud activities undertaken by our law enforcement partners and to facilitate the monitoring of cases referred to the OIG, the FBI or the U.S. Attorneys.

As other Federal government agencies acquire access to the FID, we will be able to prevent a provider who defrauds one Federal program from ever repeating the fraud in another program.

Utilizing the combined forces of all of the programs and technology cited thus far, HCFA has succeeded in preventing millions of dollars in Medicare and Medicaid losses due to fraud and abuse. However, there are still some areas where we can become more effective in these efforts, with the help of additional legislation proposed by the President's Budget.

THE PRESIDENT'S LEGISLATIVE PROPOSALS

HIPAA provided a solid foundation on which to build program integrity activities. The President is proposing a number of additional fraud and abuse proposals in his FY98 Budget and the Medicare and Medicaid Fraud, Abuse, and Waste Prevention Amendments of 1997.

THE PRESIDENT'S FY 98 BUDGET

The President's budget contains a number of proposals to reduce waste, fraud and abuse in the Medicare program. They include provisions to require insurance companies to report the insurance status of beneficiaries to ensure that Medicare pays appropriately. Private insurance is the primary payer when Medicare beneficiaries have such coverage and Medicare is required to be the secondary payer. Having insurance companies report information on Medicare beneficiaries they insure would greatly reduce the costly "pay and chase" method that we are forced to use.

In addition, we have several proposals to prevent excessive and inappropriate billing for home health services. We are proposing to close a loophole in the current payment calculation by linking payments to the location where care is actually provided, rather than the billing location. When we implement a home health prospective payment system (PPS), we are proposing to eliminate home health agency (HHA) periodic interim payments, which were originally established to encourage HHAs to join Medicare by providing a smooth cash flow. Since over 100 new agencies join Medicare each month, such financial inducements are no longer needed. We also propose to work with the medical community to develop more objective criteria for determining the appropriate number of visits for specific conditions, so that we can prevent excessive utilization.

MEDICARE AND MEDICAID FRAUD, ABUSE AND WASTE PREVENTION AMENDMENTS OF 1997

In March, the President presented an additional set of legislative proposals titled the "Medicare and Medicaid Fraud, Abuse, and Waste Prevention Amendments of 1997." Some of these proposals build on the provisions enacted in HIPAA. Others seek to close loopholes or weaknesses in the Medicare statute that allow providers to take advantage of Medicare payment. Some of the provisions in the bill include:

● **Improving the Provider Enrollment Process** - We propose to clarify the provider enrollment process, and strengthen HCFA's ability to combat fraud and abuse by not allowing "bad actors" to become Medicare providers or suppliers. These provisions would provide the Secretary the authority to deny Medicare entry for those provider applicants who have been convicted of a felony, and the authority to collect a fee for all Medicare and Medicaid applicants when they apply for enrollment or re-enrollment. The fee would cover administrative costs in processing applications and administering the HIPAA National Provider Identification program requirements. If an application is denied, a six-month waiting period must be completed before the provider could reapply.

This Subcommittee recommended in its 1981 Home Health Report that HCFA develop a data bank of owners, principals, and related organizations. We responded to this recommendation by developing a National provider enrollment application (HCFA 855) that captures that specific data for all Medicare providers, and the application will be available and effective on July 1, 1997. In conjunction with this data collection, we also intend to implement an electronic system (Provider Enrollment, Chain, and Ownership System) that will consolidate data collected by the enrollment application from fiscal intermediaries, carriers, and the National Supplier Clearinghouse. This system will maintain all existing provider data in one National repository.

● **Value of Capital When Ownership of an Institution Changes**- This proposal, which would apply to all providers, would deem the sales price of an asset to be its net book value. There have been instances in which SNFs or hospitals currently game the system by creating specious "losses" in order to be eligible for additional Medicare payments. For example, a seller might claim that a significant portion of the purchase price of a hospital is attributable not to the value of the hospital building and other capital assets, but to the value of the certificate of need, the already assembled hospital staff, or some other intangible asset. By minimizing the value attributable to the capital assets, the seller is able to record a lower sales price, and a greater "loss" on the sale. The seller is then entitled to partial reimbursement for the loss from Medicare. This existing loophole is especially problematic in the case of hospitals paid under PPS for capital because the prospective capital payments to the new owner are unaffected by the low valuation of the hospital (prior to PPS, the new owner would be somewhat disadvantaged by the gaming because their cost-based capital payments would have been lower because of the low sales price). Further, this proposal would eliminate the need for any payment adjustments for gains or losses.

● **Bankruptcy Provisions** - These proposals would protect the public's interests in bankruptcy situations. - A provider would still be liable to refund overpayments and pay penalties and fines even if it filed for bankruptcy. Quality of care penalties could be imposed and collected, and Medicare suspensions and exclusions (including educational loan defaults) would still be in force even if a provider files for bankruptcy. Bankruptcy courts would not be able to re-adjudicate our coverage or payment decisions.

● **Clarify the Definition of Skilled Service for the Purposes of Home Health Eligibility** - Venipuncture, which currently qualifies as skilled nursing care and therefore meets the eligibility criterion for intermittent skilled nursing services under the home health benefit, would be excluded. Under current law, if the other criteria are met (homebound, etc.), then a beneficiary who only

requires venipuncture for the purpose of obtaining a blood sample as his/her qualifying skilled need would be entitled to all of the other covered home health services including home health aide services.

● **Hospice Benefit Modifications** - This proposal would revise Medicare hospice coverage and payment policies in certain cases. First, after the two initial 90-day periods, this proposal would replace the current unlimited fourth hospice benefit period with an unlimited number of thirty-day periods. This change would help HCFA ensure that the hospice benefit is used for those beneficiaries with a terminal illness, but it would not end hospice care for those fortunate to survive longer than expected. Thirty-day re-certifications would, in fact, help ensure that only terminally ill patients continue to receive hospice care. Second, as the President's FY98 budget bill proposed for home health, this proposal would link payment for hospice services provided in the home to the geographic location of the site where the service was furnished. Third, this proposal would also limit beneficiary liability under hospice care. Currently, the major cause for denial of hospice claims is the fact that the beneficiary was not terminally ill within the meaning of the law (i.e., did not have a prognosis of six months or less of life expectancy at the time the services were rendered). If a hospice claim is denied because the patient was not terminally ill, the patient's liability for payment would be waived and the hospice would be liable for the overpayment unless it could prove that it did not know or have reason to know the claim would be disallowed. The standard of proof would be high since both the law and HCFA instructions are explicit as to the requirement and there are well established protocols for documentation of medical prognosis. Fourth, this proposal would create a new civil money penalty for physicians who certify that an ineligible individual meets Medicare requirements for hospice services eligibility, while knowing that the individual does not meet the requirements.

● **Rural Health Clinic (RHC) Benefit Reforms** - Recognizing the importance of the rural health clinics, reforms are needed to strengthen Medicare policy and better target assistance. It should be emphasized that the inclusion of RHC proposals in the Fraud and Abuse Prevention bill is not meant to imply that we believe these providers are engaged in fraudulent or abusive activities. We do believe, however, that the RHC program could be better targeted to serve truly under-served rural areas, and as such, we have included several proposals to address this issue. These proposals would hold provider-based RHCs to the same payment limits as independent RHCs. The Secretary would also develop a prospective payment system for RHCs no later than December 31, 2000. Under such a system, beneficiary cost sharing would be based on 20 percent of the PPS amount. Prior to the development of a PPS system, beneficiary cost sharing would not be allowed to exceed 20 percent of Medicare's payment limit. The proposal would also include provisions to better target the placement of RHCs in under-served areas and still provide access to clinic services.

● **Clarify the Partial Hospitalization Benefit** -- A partial hospitalization program uses a multi-disciplinary team to provide coordinated services within an individualized treatment plan to severely mentally ill individuals; partial hospitalization may occur in lieu of an inpatient psychiatric hospitalization or continued psychiatric hospitalization. These intensive outpatient day programs include individual and group therapy, family counseling, occupational and activity therapy, diagnostic services, and drugs that cannot be self-administered. These programs are intended for patients who would be likely to be hospitalized without these services.

This proposal would establish Medicare coverage requirements and limitations to minimize program abuse, and would also preclude providers from furnishing partial hospitalization services in an individual's home or in an inpatient or residential setting. It would provide the Secretary broad authority to establish through regulation a prospective payment system for partial hospitalization services that reflects appropriate payment levels for efficient providers of service and payment levels for similar services in other delivery systems. The current cost reimbursement system would stay in place until the Secretary exercises this payment authority. In addition, this proposal would provide authority for the Secretary to establish (through regulation) Medicare participation requirements, such as health and safety requirements and provider eligibility standards for community mental health centers (CMHCs). Additionally, it would provide authority for CMHCs to be surveyed upon request by state agencies to determine compliance with Federal requirements or investigate complaints. It would also prohibit *Medicare-only* CMHCs. Finally, the bill includes a provision (which parallels the authority created in HIPAA for false certification of home health services) to penalize physicians for inappropriate admissions to partial hospitalization programs; this provision would create a strong incentive for physicians to certify need for partial hospitalization services only for those individuals who meet Medicare requirements.

FUTURE CHALLENGES.

Health care delivery systems, like every other aspect of society, evolve over time. The current trend toward managed care as an alternative to the traditional fee-for-service system is a phenomenon which promises to change the face of the health care environment. This is because the type of integrated health care network that managed care provides can be a boon --- or a bane --- to elderly Medicare and Medicaid beneficiaries. Currently, we have only 12% of our beneficiaries in managed care, but in the future we will need to take a fresh look at our strategy to fight fraud and abuse, because the incentives are different in this type of delivery system. The emphasis on cost-effectiveness prevalent in managed health care delivery systems ensures fiscal soundness and value for the customer, but in some instances, unethical plans and providers may discourage or withhold needed care from beneficiaries.

In the same way, the growth spurt we are witnessing in the home health care industry indicates that as innovative new health care arrangements flourish, so will new opportunities for fraud and abuse. Growing numbers of the elderly, and especially of dual eligibles, also means increasing opportunities for those who seek to defraud Medicare and Medicaid patients, providers, and health plans. In home health settings, the physical isolation of the beneficiary is often an open invitation to unethical providers seeking ways to provide care based on financial incentives, rather than care that is actually needed. Not surprisingly, this problem also exists in nursing homes. The vulnerability of home health and nursing home patients suggests that very ill or elderly patients may be targeted because they may not be able to monitor their own bills for fraudulent charges. There is evidence that wherever there are concentrations of the frail elderly, there are providers seeking to provide unnecessary services.

Another area in which the elderly may be especially vulnerable is the services provided to beneficiaries with no roots in the community, such as recent immigrants or "snowbirds" who may be unable to ascertain the qualifications or credibility of the provider or supplier. Particularly in areas with high concentrations of elderly retirees from other States, profiteers can re-locate from city to city, often operating under aliases or fraudulent identification numbers. With the authority to collect Social Security numbers, we would be able to substantially reduce this threat.

Health care mega-corporations also pose challenges for fraud detection and prevention. New mergers and acquisitions are resulting in ever-larger health care corporations, which will be more difficult to monitor for fraud and abuse. On the other end of the spectrum, small walk-in "urgent care" facilities that are proliferating nationwide are difficult to monitor and also offer opportunities for fraud and waste. The challenge for HCFA and the Medicare program will be to understand the relationships between health care entities in order to understand the potential for kickbacks and other illegal relationships. When business relationships become complex and convoluted, they are hard to track; more time is needed to identify and confirm relationships and billing abuses.

Finally, mental health benefits and their potential misuse are a particular area of concern in fraud and waste detection. There have been numerous cases of mental health benefits ordered for individuals who are unable to benefit from them, or conversely, necessary mental health benefits are often being prescribed but not adequately provided. We need to be a step ahead of corrupt providers and suppliers who seek to defraud Medicare and Medicaid's allocated funds, which are essentially investments by taxpayers and which must be safeguarded for future generations

CONCLUSION

The implementation of HIPAA has given us powerful weapons against waste, fraud, and abuse. The work of this Committee and other Members of Congress on HIPAA has been vital to this important legislation, which will increase our ability to protect the integrity of the Medicare program, and to safeguard the interests of our beneficiaries. Most importantly, the lessons and experience gained from our efforts in the past few years will guide us as we put our new legislative and administrative tools to use. By effectively utilizing the solid partnerships between State and Federal agencies, the public, and private health care organizations, we will preserve Medicare and Medicaid for future generations.

GAO

United States
General Accounting Office
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Health, Education and Human Services Division

B-271640

June 17, 1997

The Honorable Charles E. Grassley
Chairman, Special Committee on Aging
United States Senate

Subject: Medicare: Problems Affecting HCFA's Ability to Set Appropriate Reimbursement Rates for Medical Equipment and Supplies

Dear Mr. Chairman:

Medicare spent over $4.3 billion in 1996 for medical equipment and supplies,[1] such as walkers, catheters, and glucose test strips for its beneficiaries. Problems in setting payment rates, however, raise concerns about whether the Health Care Financing Administration (HCFA) paid too much for these items. Our prior studies[2] and a report by the Office of the Inspector General (OIG)[3] in the Department of Health and Human Services (HHS) have documented that Medicare pays higher-than-market rates for some items. HCFA recognizes that it pays too much for some medical equipment and supplies, as we have reported, but believes a slow and cumbersome regulatory process for adjusting Medicare's payment rates severely hinders its efforts to address overpricing.

At your request, we are currently reviewing the underlying problems associated with setting appropriate Medicare reimbursement rates for medical

[1]This amount includes expenditures for prosthetics, orthotics, and pharmaceutical drugs (such as nebulizer drugs) used in conjunction with durable medical equipment as well as expenditures for medical equipment and supplies.

[2]See Medicare: Excessive Payments for Medical Supplies Continue Despite Improvements (GAO/HEHS-95-171, Aug. 8, 1995) and Medicare Spending: Modern Management Strategies Needed to Curb Billions in Unnecessary Payments (GAO/HEHS-96-210, Sept. 19, 1996).

[3]Durable Medical Equipment - Review of Medicare Payments for Home Blood Glucose Monitors, HHS OIG, A-09-92-00034 (Washington, D.C.: Dec. 1992).

equipment and supplies. Because the Congress may shortly consider legislation on Medicare payment rates, however, your office requested that we provide you with interim information on the problems we have identified to date. Specifically, this correspondence identifies two basic problems with the Medicare reimbursement system for medical equipment and supplies: (1) HCFA does not know specifically what products it is paying for when it pays claims and (2) Medicare reimburses large suppliers and individual beneficiaries at the same rates, even though those rates do not account for the discounts large suppliers negotiate with manufacturers and wholesalers.

To develop our information, we analyzed Medicare payments for off-the-shelf, commonly used medical equipment and supplies. We also reviewed the laws, regulations, coding systems, and fee schedules for Medicare's payments for medical equipment and supplies. We obtained data on Medicare payments from HCFA's carriers and the statistical analysis contractor. We obtained information on product pricing, distribution channels, and purchasing practices through discussions with manufacturers, suppliers, and industry groups. We also collected prices and acquisition costs for selected items from HCFA contractors, various suppliers, wholesalers, manufacturers, a state Medicaid agency, and the Department of Veterans Affairs.

Finally, we obtained information on universal product numbering systems for medical products from the Department of Defense (DOD); associations representing medical equipment suppliers, distributors, and manufacturers; and a group of hospital buying groups, health care providers, manufacturers, and distributors working on building a consensus for product identification standards.

We performed our field work between March 1996 and June 1997 in accordance with generally accepted government auditing standards, except for (1) auditing the cost and pricing information obtained from suppliers and (2) examining the internal and data processing controls of the Medicare claims databases maintained by HCFA's contractors. The cost and pricing information we received from the multiple suppliers was fairly consistent. In addition, the statistical reports obtained from the Medicare claims databases were not critical to our findings.

RESULTS IN BRIEF

HCFA does not know specifically what products it is paying for when it pays Medicare claims for medical equipment and supplies, according to our work to date. HCFA does not require suppliers to identify specific products on their

Medicare claims. Instead, suppliers use HCFA billing codes, some of which cover a broad range of products of various types, qualities, and market prices. For example, suppliers use one Medicare billing code for more than 200 different urological catheters, even though some catheters sell at a fraction of the price of others billed under the same code. Because Medicare pays suppliers the same amount for all the products covered by a billing code, the reimbursement system gives suppliers a financial incentive to provide Medicare patients with the least costly products covered by a billing code. In addition, because Medicare claims do not identify the specific product provided, HCFA lacks the information it needs to ensure that each billing code is used for comparable products.

To identify specific medical equipment and supplies, DOD and some other major purchasers are beginning to require suppliers to use a universal product numbering system. This system, which can also be used for bar coding the products, enables purchasers and insurers to identify specific products being used and track reimbursements for each product and groups of similar products as well as the market prices of specific products. HCFA officials, on the other hand, have not begun exploring the possibility of using the universal product numbering system in the Medicare program.

Medicare reimburses large suppliers and individual beneficiaries the same amounts for medical equipment and supplies, even though large suppliers negotiate substantial discounts with manufacturers and wholesalers, while individual beneficiaries pay retail prices. Large suppliers provide some products, such as urological catheters and drainage bags, to nursing homes and home health agencies, which then provide them to individual Medicare beneficiaries. In turn, the large suppliers can bill Medicare directly and get reimbursed at fee-schedule rates based on historical charges and catalog prices. For example, one supplier's weighted average cost for all catheters billed in 1996 under one Medicare billing code was less than $1 per catheter; however, Medicare reimbursed the supplier at the program's fee-schedule allowance of $10 to $12 per catheter. HCFA has not considered establishing a separate fee schedule for products provided to nursing home and home health patients that accounts for their suppliers' substantially lower acquisition costs compared with the cost of products beneficiaries purchase directly.

BACKGROUND

Medicare covers a wide variety of medical equipment, such as walkers and canes, and supplies such as urinary catheters, drainage bags, glucose test strips,

and ostomy products.[4] Medicare part B insurance covers these products for beneficiaries who live at home or in facilities used as homes, such as nursing homes.[5] Medicare pays 80 percent of the allowed amount, which is the lower of the actual charge submitted by the supplier or the amount allowed under a fee schedule. Medicare beneficiaries pay for the remaining 20 percent of the allowed amount.

HCFA classifies medical equipment and supplies into groups using the HCFA Common Procedure Coding System (HCPCS). HCFA assigns each group of products an HCPCS code intended to cover similar items, and all items covered by a code are reimbursed at the same rate. When suppliers submit a Medicare claim, they must specify an HCPCS code to identify the group that they believe best describes the specific item provided to the Medicare patient.

Four HCFA contractors, called Durable Medical Equipment Regional Carriers (hereafter referred to as carriers), process and pay Medicare claims for medical equipment and supplies.[6] Each carrier covers a separate region of the country. The Statistical Analysis Durable Medical Equipment Regional Carrier (referred to as the statistical analysis contractor) analyzes claims processed by the carriers and ensures that the carriers and suppliers uniformly interpret and use the HCPCS codes.[7]

Most Medicare part B payments for medical equipment and supplies are based on a fee-schedule system set forth under section 1834 of the Social Security Act.[8] Under this system, HCFA calculates a fee-schedule allowance for each HCPCS code for each state. The allowances for each state are based on the average historical charges that suppliers submitted in 1986 and 1987; the

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[4]Medicare part A covers inpatient care in a hospital or skilled nursing facility and home health or hospice care. Medicare part B covers physician services, outpatient hospital services, durable medical equipment, and various other health services.

[5]Medicare part B does not cover medical equipment and supplies for patients in skilled nursing facilities whose stay is covered by part A.

[6]These carriers are also known as DMERCs.

[7]The Statistical Analysis Durable Medical Equipment Regional Carrier is also known as the SADMERC.

[8]42 U.S.C. 1395m.

historical charges are indexed forward using the consumer price index. To reduce variation among state payment rates, the state fees are subject to national floors and ceilings. The national floor is 85 percent of the median of all the state fees, and the ceiling is the median of all state fees for each billing code. No state fee may exceed the national ceiling or be less than the national floor.

For new medical equipment and supplies that do not match the description of an HCPCS code, the carriers use a gap-filling process to establish reimbursement rates. This process involves the carriers' creating a product price list by using the suggested retail prices found in catalogs. The fee-schedule allowance is the lower of the average or the median suggested retail prices found for products covered under the new HCPCS code.

HCFA recognizes that many of the Medicare fee-schedule allowances are now out of line with current market prices because the fee-schedule allowances do not reflect changes in technology and supplier costs. Some product prices may have increased at rates lower or higher than the consumer price index, which also forces the fee allowances out of line with market rates. HCFA is trying to adjust some fee-schedule allowances, but the regulatory process mandated by statute for making such adjustments is slow and cumbersome.[9] For example, adjusting the Medicare allowance for home blood glucose monitors took HCFA almost 3 years. For this reason, the administration is seeking legislative authority to streamline the process by allowing the carriers to adjust the Medicare allowances.

HCFA'S CODING SYSTEM PROVIDES INSUFFICIENT INFORMATION FOR PROPERLY IDENTIFYING AND PAYING FOR PRODUCTS BILLED TO MEDICARE

Suppliers who bill Medicare for medical products use billing codes that do not identify the specific items provided to beneficiaries. Because Medicare pays one fee for all products in a billing code, suppliers can furnish a low-cost item to a Medicare beneficiary and get reimbursed at a rate that covers a higher cost item billed under the same code. An official of the statistical analysis contractor said that the billing system results in "winners" (suppliers who are overpaid for low-cost items) and "losers" (suppliers who are underpaid for high-cost items) and that the winners and losers likely balance out. Because HCFA cannot track what items are being billed and provided, however, it does not

[9]42 U.S.C. 1395m(a) (10) (B).

know to what extent suppliers are providing mostly low-cost items. Although the health care industry is moving toward the use of universal product numbers to more specifically identify medical equipment and supplies, HCFA has not explored this approach for improving information on products Medicare pays for.

HCFA's Coding System Does Not Identify Specific Products

HCFA's coding system for medical equipment and supplies provides insufficient information to identify the specific products suppliers provide to Medicare beneficiaries. The HCPCS coding system used by HCFA classifies medical equipment and supplies into general product groups, and, when suppliers bill Medicare, they specify the HCPCS code they believe best describes the specific equipment or supply item provided to a beneficiary. Suppliers and manufacturers may also petition HCFA or the carriers to establish new HCPCS codes for products they believe are not adequately described by or reimbursed under the HCPCS codes.

Some HCPCS codes are used for products that differ widely in properties, uses, and performance. Yet Medicare pays the same fee-schedule allowance (with minor variations among states) for all products billed under the same HCPCS code. For example, the HCPCS code for latex foley catheters[10] includes more than 200 short-term, medium-term, and long-term catheters. According to one manufacturer of foley catheters, specialized coatings affect the durability, function, and price of these catheters. Wholesale prices of these catheters range from $1.09 for a short-term catheter to $17.90 for a long-term catheter. Medicare's 1997 national floor and ceiling were $9.95 and $11.70, respectively, for all catheters in this HCPCS code.

The fee-schedule system used in conjunction with the HCPCS codes provides a financial incentive for suppliers to provide low-cost items to Medicare beneficiaries, and these items may or may not meet the patient's medical needs. Suppliers can increase their profits by charging Medicare the full fee-schedule allowance for a low-cost product that technically fits the code description. For example, although multiple types of latex foley catheters may be classified under the same HCPCS code, information we gathered from some suppliers showed that the basic short-term catheter was both the least expensive and the

[10]A latex foley catheter is typically billed under HCPCS code A4338 (in-dwelling catheter; foley type; two-way latex with coating, such as Teflon, silicone-coated, silicone elastomer, or hydrophilic).

most commonly provided catheter. HCFA cannot readily perform this type of analysis because suppliers do not have to identify the specific products for which they submit claims.

Industry groups and suppliers we contacted said they find the HCPCS coding system difficult to use. Suppliers and manufacturers often need help in deciding which HCPCS code is appropriate for specific products. In response, the statistical analysis contractor has set up a hot line to handle coding inquiries and medical policy and pricing questions; the hot line receives an average of 8,000 calls a month. Coding inquiries account for about 80 percent of the hot line's monthly calls. Coding inquiries about the HCPCS codes for ostomy and incontinence supplies are among the most prevalent.

Product-Specific Codes Are Available to Track Utilization

DOD and some hospital health care purchasing groups are beginning to require their suppliers to use product-specific codes, called universal product numbers, to identify individual medical products. This system requires manufacturers to bar code each product to identify characteristics such as the manufacturer identification number, product type, and packaging unit. Universal product numbers will enable these government and private purchasers to develop standard product groups, track market prices, and use prudent purchasing methods--paying for the medical equipment and supplies that meet quality standards at competitive market prices. Industry groups contend that Medicare, the nation's largest health care insurer, should be leading the effort to require the use of universal product numbers, especially because this coding system will allow HCFA to better classify products by HCPCS code, monitor suppliers' use of the billing codes, and adjust the Medicare fee-schedule allowances to more current market-based prices.

We met with HCFA officials to discuss the benefits of the bar coding system to the Medicare program, though HCFA has not yet explored using universal product numbers to track the cost and utilization of specific medical products. HCFA officials have not taken a position on using this coding system, according to discussions with us. At this time it is unclear whether the Secretary of HHS will promulgate universal product numbers as a product identification standard using the authority provided by the Health Insurance and Portability Act of 1996.[11]

[11]P.L. 104-191, 110 Stat. 1936 (1996).

B-271640

MEDICARE'S FEE SCHEDULE OVERPAYS LARGE SUPPLIERS

Medicare reimburses large suppliers who buy at volume discounts the same fee-schedule allowances as individuals who buy single items at retail prices. Large suppliers who bill Medicare include home medical equipment and supply companies and distributors who submit claims on behalf of beneficiaries in nursing homes. Because these suppliers submit claims on behalf of many beneficiaries, they can negotiate volume discounts for the products they buy. Individual beneficiaries, on the other hand, lack the purchasing power to obtain volume discounts. Therefore, fee-schedule allowances that adequately reimburse individual beneficiaries usually overpay large suppliers, even after accounting for their administrative costs.

The largest suppliers receive a significant portion of Medicare spending for many medical products. Although more than 150,000 suppliers bill Medicare for medical equipment and supplies, claims submitted by the top 10 suppliers often represent a large percentage of total allowed charges for certain HCPCS codes. For example, for one particular urological HCPCS code, the top 10 suppliers accounted for almost 55 percent of charges billed to Medicare between July 1, 1996, and September 30, 1996, according to our analysis. For five other HCPCS codes in our study, 10 suppliers accounted for 24 percent or more of total allowed charges.

Medicare's fee-schedule allowances are excessive compared with large suppliers' acquisition costs for some products. For example, one supplier reported that its weighted average cost for items billed in 1996 under the HCPCS code for a foley catheter was less than $1. Medicare's reimbursement for each catheter was between $10.06 and $11.83, the 1996 respective national floor and ceiling for this item. In the same year, another supplier's weighted average cost for a bedside drainage bag was about $2.25, though Medicare reimbursed the supplier between $7.65 and $9 for this item.

On the other hand, for some products, such as ostomy supplies, new technology has increased product quality and prices, and the Medicare payment rates do not adequately reimburse either suppliers or individual beneficiaries for these items. In such cases suppliers often do not accept claim assignment--making the Medicare beneficiary responsible not only for the 20-percent copayment, but also for the difference between the supplier's charge and the Medicare allowance.

Suppliers who bill Medicare on behalf of the beneficiary incur administrative costs associated with filing a claim. Most of these costs involve documenting

medical necessity for the initial claim. Subsequent claims to reorder items for the same beneficiary take less time because suppliers have already gathered much of the information for the initial claim. According to suppliers, urological and ostomy products are the types of items that are often reordered.

Suppliers estimate that the average administrative cost for filing a Medicare claim for a reordered product is about $10. Because suppliers typically include several related supplies on a single claim, this administrative cost is disbursed among multiple items. For example, a claim for a foley catheter may also include an insertion tray, a bedside drainage bag, and a leg drainage bag if the patient is mobile. Disbursing the administrative cost among the three or four items reduces this cost to between $2.50 and $3.35 per item.

Market competition to reduce product costs has driven suppliers to increase their purchasing power by consolidating with similar businesses or joining purchasing cooperatives. Hospitals, nursing homes, and suppliers have formed their own purchasing groups to get lower prices from manufacturers. The medical equipment and supplies market is constantly changing as suppliers seek to lower costs and gain new market share. Mergers, consolidations, acquisitions, and buying cooperatives have produced suppliers with greater purchasing power to lower product acquisition costs.

Although competitive market pressures have driven suppliers to find new ways to reduce their product costs, Medicare's fee schedule does not account for the savings from these cost efficiencies. Some large suppliers have contractual arrangements and corporate affiliations with nursing facilities and home health agencies. These arrangements allow suppliers to take advantage of significant volume discounts from manufacturers and wholesalers. HCFA, however, has not considered establishing a separate fee schedule to account for discounts for nursing facilities and home health providers that furnish medical products to beneficiaries in their care.

AGENCY COMMENTS

We made a draft of this correspondence available for review by HCFA program officials, and we also discussed the issues with them. The agency officials with whom we spoke expressed uncertainty about the benefits of using universal product numbers in the Medicare program and about the need for a separate fee schedule for medical equipment and supplies furnished to patients in nursing homes or through home health providers. We will provide HHS and HCFA an opportunity to comment in writing on our final report, which we expect to provide you in September 1997.

B-271640

As agreed with your office, unless you release its contents earlier, we plan no further distribution of this letter for 30 days. At that time we will make copies available to other congressional committees and members of the Congress with an interest in these matters and the Secretary of Health and Human Services.

Please call William Reis at (617) 565-7488 or me at (202) 512-7114 if you or your staff have any questions about the information in this letter. Other contributors to this study were Teruni Rosengren, Suzanne Rubins, and Thomas Taydus.

Sincerely yours,

William J. Scanlon

William J. Scanlon
Director, Health Financing and
Systems Issues

(101502)

Foley Latex Catheters
Billed Under Medicare HCPCs Code A4338
Senate Permanent Subcommittee on Investigations
EXHIBIT # 2
WHOLESALE PRICE $1.09
SHORT-TERM
WHOLESALE PRICE $5.19
MEDIUM-TERM
WHOLESALE PRICE $17.90
LONG-TERM
MEDICARE 1997 FEE SCHEDULE ALLOWANCE
• FLOOR $9.95
• CEILING $11.70

United States General Accounting Office

GAO

Report to the Ranking Minority Member, Subcommittee on Labor, Health and Human Services, Education, and Related Agencies, Committee on Appropriations, U.S. Senate

June 1997

MEDICARE

Need to Hold Home Health Agencies More Accountable for Inappropriate Billings

GAO/HEHS-97-108

GAO

United States
General Accounting Office
Washington, D.C. 20548

Health, Education, and
Human Services Division

B-270233

June 13, 1997

The Honorable Tom Harkin
Ranking Minority Member
Subcommittee on Labor, Health
and Human Services, Education,
and Related Agencies
Committee on Appropriations
United States Senate

Dear Senator Harkin:

Medicare, the nation's health insurance program for the elderly and disabled, is the single largest payer for home health services. Between 1988 and 1996 Medicare spending for home health grew from $2.1 billion to $18 billion and by the year 2000 is projected to exceed $21 billion. Along with increasing expenditures, the number of home health agencies has also increased—from about 5,800 to over 9,000.

This growth and accompanying reports of overutilization of home health services have raised questions about Medicare's ability to detect and prevent inappropriate payments for this component of the Medicare program. Congressional committees have held hearings this year on proposals to control the growth in home health billings. Under any proposal adopted, however, there would be a continued need to monitor Medicare payments effectively.

At your request, we (1) examined the weaknesses of existing Medicare controls over the home health benefit, (2) identified lessons learned from examining private insurers' controls over home health payments and recent federal antifraud initiatives, and (3) identified a management approach that could improve Medicare's ability to avoid substantial payments attributable to abusive billing practices.

To conduct our study, we selected a sample of 80 high-dollar home health claims that had been processed in May 1995 and had been approved without review. We asked a Medicare claims-processing contractor to review the sample for the appropriateness of the charges and services claimed. We also analyzed information obtained from officials of the Health Care Financing Administration (HCFA), the agency within the Department of Health and Human Services (HHS) responsible for administering Medicare; data obtained from Medicare's claims-processing

contractors; and information from the HHS Office of the Inspector General. In addition, we analyzed information obtained from officials of private insurance companies and the Office of Personnel Management, which oversees the Federal Employees Health Benefits Program. (See app. I for a more detailed description of our scope and methodology.)

Results in Brief

We and others have reported on several occasions about problems with Medicare's review of home health benefits (see the list of related products at the end of this report). Yet, in spite of the need for increased scrutiny indicated by these reports and by the growth in home health expenditures, Medicare's review of home health claims decreased in the 1990s. In our test of just 80 high-dollar claims that had been processed without review, the Medicare claims-processing contractor, after examining each claim and supporting documentation, denied more than $135,000 in charges (about 43 percent of total charges) for 46 of the claims. The reasons for the denials included failure to substantiate medical necessity, noncoverage of services or supplies, and inadequate documentation, including the absence of physician orders. These findings are consistent with prior federal investigations, one of which estimated that in the month of February 1993 alone, Medicare paid $16.6 million for home health claims in Florida that should have been disallowed.

The five private insurers we contacted use controls that, although not readily adaptable to Medicare's coverage terms or billing rules, are nevertheless instructive regarding the monitoring of claims. The insurers employ professional staff, such as nurses, to determine in advance the legitimacy of the request for home health services. In contrast, HCFA relies on home health agencies' compliance with administrative procedures, such as obtaining a physician's signature for ordered services, to safeguard against the submission of improper claims. While Medicare does not have sufficient administrative funds to undertake the intensity of claims monitoring done by the private insurers we reviewed, the vigilance of private insurers suggests the value of applying more scrutiny in this area.

Reduced funding for payment safeguards in recent years helps explain the marked absence of adequate claims reviews by Medicare contractors. Ten years ago, over 60 percent of home health claims were reviewed. In 1996, Medicare intermediaries reviewed only 2 percent of all claims. New and more stable funding provided through the Health Insurance Portability and Accountability Act (HIPAA) of 1996 (P.L. 104-191) should help improve Medicare's performance in monitoring home health payments, but HCFA

also needs an enforcement tool—a preventive approach—that will make providers accountable for the propriety of their claims. Therefore, we are suggesting that the Congress consider directing HCFA to test an approach that would systematically identify and penalize providers that habitually bill Medicare inappropriately. Under this approach, billing offenders would be identified and, if found to have excessively high billing errors, those offenders, rather than the taxpayer, would be required to shoulder the cost burden of investigative claims reviews. We believe that such an approach could also serve as a deterrent to future billing abuses.

Background

Medicare is a health insurance program that covers over 38 million elderly and disabled people. The program, authorized by title XVIII of the Social Security Act, provides coverage under two parts. Part A, the hospital insurance program, covers inpatient hospital services, posthospital care in skilled nursing homes, and care in patients' homes. Part B, the supplementary medical insurance program, covers primarily physician services but also a number of other services, including home health care for beneficiaries not covered under part A. Almost all Medicare payments for home health care are made under part A.

Beneficiary Eligibility for Home Health Benefit

Since the late 1980s when a court decision obligated HCFA to interpret more liberally Medicare's eligibility and coverage criteria, beneficiaries have more easily obtained home health coverage than previously. To qualify, individuals must be confined to their residences (be "homebound"), be under a physician's care, and need part-time or intermittent skilled nursing care and/or physical or speech therapy. In meeting these requirements, beneficiaries are covered for visits by home health aides, medical social workers, and occupational therapists. Required medical supplies are also covered.

Services must be furnished under a plan of care prescribed and periodically reviewed by a physician. As long as the care is reasonable and necessary, there are no limits on the number of visits or length of coverage. Medicare does not require copayments or deductibles for home health care, except for durable medical equipment.

Home Health Agency Participation Requirements

Medicare law requires that home health agencies be certified to serve Medicare beneficiaries. The agencies obtain certification by meeting specific requirements, commonly referred to as conditions of

participation. These requirements cover the agency's qualifications and capacity to perform such administrative functions as appropriate recordkeeping, including patient privacy protections, and such provider functions as the administering of skilled nursing services.

Typically, HCFA contracts with state public health agencies to conduct certification and recertification surveys of home health agencies. Generally, home health agencies found to be out of compliance are provided an opportunity to develop a corrective action plan. If the state agency and HCFA approve the plan, the home health agency can continue to participate in Medicare; it can maintain certification if the plan results in correction of the problems identified.

Oversight of Home Health Payments

Regional claims-processing contractors, called intermediaries, process and pay claims submitted by over 9,000 home health agencies, which are paid on the basis of the costs they incur up to predetermined cost limits. In 1995, claims received from home health agencies represented about 14 percent of all part A claims and 13 percent of part A expenditures.

Intermediaries are responsible for ensuring that Medicare does not pay home health claims when beneficiaries do not meet the Medicare home health criteria, when services claimed are not reasonable or necessary, or when the intensity of services exceeds the level called for in an approved plan of treatment. They carry out these responsibilities through medical reviews of claims.

Medical review can be performed either before or after a claim is approved for payment and involves obtaining home health agency documentation, such as the beneficiary's plan of care and medical records. Occasionally, intermediaries conduct site visits—a postpayment review at the location of a home health agency, where reviewers can examine plans of care and other medical documentation. Because of budgetary constraints in recent years, intermediaries review only about 1 to 3 percent of all claims. They typically only target providers that have high unexplained utilization rates.

Medicare Lacks Adequate Controls to Effectively Monitor Home Health Payments

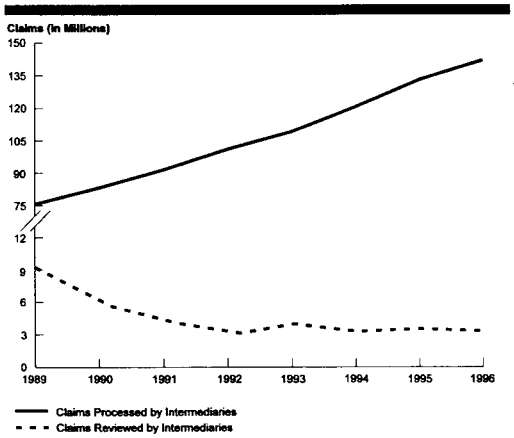
Our work in recent years has shown that because of insufficient funding of payment safeguards, HCFA's monitoring has been unable to keep pace with the increasing volume of home health claims submitted to Medicare. This situation may be one of the factors contributing to the rapid growth in Medicare's home health expenditures.

Funding Constraints Limit Medical Review of Claims

The relationship between funding levels and claims reviewed helps explain Medicare's current predicament. In 1985, legislation more than doubled claims review funding, enabling intermediaries to review over 60 percent of the home health claims processed in fiscal years 1986 and 1987. By 1995, however, when payment safeguard funding for part A medical review had substantially declined (from $61 million in 1989 to $33 million in 1995), the intermediaries' claims review target had been lowered to 3.2 percent for all part A claims (or even lower, depending on available resources, to a required minimum of 1 percent).[1] During this period, the number of home health agencies participating in Medicare increased by more than a third, and the volume of home health claims processed more than tripled. Figure 1 illustrates how the total number of claims processed by intermediaries has risen since 1989, while the number of claims reviewed has generally declined.

[1]Because this review target is the minimum for part A claims as a group, the actual percentage of home health claims reviewed could be higher or lower than the target level specified.

Figure 1: Numbers of Claims Processed and Reviewed by Intermediaries Since 1989



Note: Numbers are for all part A claims, including home health claims. Data for claims processed are by fiscal year; data for claims reviewed are by calendar year.

Source: HCFA data.

In our March 1996 report on the deterioration of Medicare's home health payment controls, we noted the effects of reduced funding on efforts to deter abusive billing.[2] We found that the infrequency of the intermediaries' medical review of claims and limited physician involvement in overseeing home health agencies' plans of care made it nearly impossible to determine whether the beneficiary receiving home health services qualified for the benefit, needed the care being delivered, or even received the services being billed to Medicare. Also, because of the small percentage of claims selected for review, home health agencies that billed

[2]Medicare: Home Health Utilization Expands While Program Controls Deteriorate (GAO/HEHS-96-16, Mar. 27, 1996).

for noncovered services were less likely to be identified than was the case a decade earlier.

HIPAA, which now ensures funding for program safeguards through 2003, allows HCFA to count on stable funding in the coming years. However, per-claim expenditures for medical review and other controls will remain below the 1989 level after adjusting for inflation. We project that in 2003, payment safeguard spending as authorized by the act will be just over half of the 1989 per-claim level, after adjusting for inflation.

Better Controls Over Payments Needed

In recent years, we have reported on the marked absence of HCFA guidance for intermediaries on monitoring high-dollar claims despite postpayment reviews that have found Medicare paying substantial sums for claims not satisfying key payment criteria. In a recent test, we asked one regional intermediary—Blue Cross of California—to do medical reviews for a sample of high-dollar home health claims that it had originally processed and approved without review.

We selected 80 claims from the universe of home health claims processed by the California intermediary in May 1995 (see app. I for a more detailed description of how these claims were selected). The intermediary found that 46 of the 80 claims submitted by 26 home health agencies should have been partially or totally denied and subsequently did deny them. For the 46 claims totaling $313,655 in charges for services and supplies, about 43 percent, or $135,640, were denied. The intermediary's reasons for the denials included failure to substantiate medical necessity, noncoverage of services or supplies, and inadequate documentation, including the absence of physician orders. Specifically, the intermediary found the following:

- Of $18,132 in charges for the care of a beneficiary's decubitus ulcer (open wound) for 30 days, 36 percent ($6,483) were denied, including charges for almost half of the skilled nursing visits (four per day) that were not considered medically necessary.
- Of $4,100 in charges for supplies related to care provided over 4 weeks, 31 percent were not adequately documented in the medical records or should have been part of the paid nurse's visit and not billed separately. About half of the amount denied was for supplies never received by the beneficiary.
- Of $17,953 in charges for medical supplies related to the treatment of a beneficiary's salivary gland disease, the intermediary denied the entire amount because the medical documentation and the itemized list of

supplies provided were not consistent and did not support the supplies the agency billed for.

- Nine of the 80 claims—representing nearly half ($61,250) of the total dollars disapproved—were denied because the home health agencies did not submit any of the medical records the intermediary had requested for the review.

The California intermediary also visited a home health agency where it reviewed supporting documentation for a random sample of 464 claims. The agency had been targeted for a comprehensive review because of its high billings. The review team found that the agency's claims for $39,384 were appropriate; however, claims for $27,834 were considered not medically necessary and were denied, and claims in the amount of $330,444 were denied for nonmedical reasons, including undated or otherwise invalid plans of care, no plan of care, and billing for supplies not covered.

The findings from our test sample of claims subjected to medical review are consistent with reports by the HHS Inspector General on home health agency fraud and abuse. A 1995 Inspector General report on home health services in Florida found that an estimated 26 percent of home health claims did not meet Medicare reimbursement requirements.[3] On that basis, the Inspector General estimated that $16.6 million of the $78 million in claims approved for payment by intermediaries in February 1993 were unallowable. Claims did not meet reimbursement requirements because beneficiaries were not homebound, services were considered unnecessary, and visits were not documented in the medical records.

Private Insurers' Approaches and Federal Initiatives Emphasize Need for Accountability

The various approaches to control home health payments used by five private insurers we examined collectively underscore the importance of implementing measures to help prevent abusive billings and also hold providers accountable for services billed. Recent federal fraud-fighting efforts targeting abusive billers in the home health industry have also demonstrated the need for greater claims scrutiny.

Private Insurer Strategies Instructive, but Not Easily Adapted to Medicare

Because of differences in beneficiary population, claims volume, and specific benefit provisions, the controls used by private insurers to contain home health costs would not be easily adapted to the Medicare program.

[3]Results of the Audit of Medicare Home Health Services in Florida (HHS/OIG, A-04-94-02087, June 16, 1995).

The five insurers we contacted use some combination of patient cost-sharing (deductibles and copayments) and caps on the number of allowed visits to help control home health utilization; however, cost-sharing and preset utilization limits are not permissible under Medicare's home health benefit provisions.

In addition, all five of the insurers routinely verify the basis for proposed plans of home care and oversee, using professional staff, how the care plans are implemented. Company-employed or contract nurses typically interview the home health agency's nurses, the discharge planner (when the patient has been hospitalized), the patient, and sometimes the family. They attempt to determine in advance the legitimacy of the patient's need for home-based medical services. Often the insurers employ utilization review nursing staffs or insurance company caseworkers to monitor and approve visits on an incremental basis. For example, one insurer approves visits in increments of 10 or fewer, or in time intervals of 2 to 4 weeks. For high-cost cases, all the insurers we examined used some form of case management that typically involved monitoring by nurses. As case managers, they track the volume of services provided, the outcomes being achieved, and the appropriateness of continuing care.

In contrast, the sheer volume of Medicare's home health claims and scarce funds for monitoring payments have resulted in an approach that relies substantially on the home health agencies themselves. In 1996, more than 10 percent of Medicare beneficiaries—roughly 4 million people—received home health services. To cope with this caseload, HCFA relies on the home health agencies to rely, in turn, on attending physicians to monitor patient progress, the proper development and periodic review of plans of care, and the medical necessity of services delivered.

Unlike their private insurer counterparts, Medicare intermediaries are not responsible for approving the plans of care developed by the home health agencies. The physician's signature on a plan of care is intended to serve as a quality control, but in practice the certifying physician may not have ever seen the patient for whom the care plan is designed. Moreover, the intermediaries' relatively few medical reviews of claims generally do not include an independent verification of the documentation prepared and submitted by the home health agencies. Likewise, although Medicare requires home health agencies to update a beneficiary's plan of care at least every 62 days, the intermediary does not routinely review updated plans. As for high-cost cases, nearly 40 percent of Medicare's home health beneficiaries receive more than 30 visits. Because of the prohibitive costs,

intermediaries cannot systematically monitor such long-term or otherwise expensive cases to ensure the care being delivered is appropriate to the patients' needs.

Federal Antifraud Efforts Target Home Health Payments

Given the growth in Medicare spending for home health services, nursing home services, and medical equipment and supplies, the HHS Inspector General and other federal and state agencies banded together to target fraudulent and abusive billing practices in these industries. This effort, called Operation Restore Trust, was conducted initially in five states and reported identifying almost $188 million in inappropriate payments in its 2 years of operation.

Among the lessons learned to date from Operation Restore Trust is the importance of coordination among the various program and enforcement agencies involved at the federal, state, and local levels. Coordination, for example, between Medicare intermediaries and state surveyors in the project's several states resulted in the decertification of many of the targeted home health agencies and in the recovery of substantial sums in inappropriate payments.[4]

For example, in investigations conducted in Louisiana and Texas, the Medicare intermediary trained state surveyors on billing and beneficiary coverage issues. The intermediary also provided a list of agencies that it believed to be billing improperly. In turn, the surveyors passed on to the intermediary information obtained from their site visits to home health agencies and beneficiaries. This exchange of information allowed the intermediary to identify claims that (1) were made on behalf of beneficiaries who were obviously not homebound, (2) billed for services not provided, and (3) billed inappropriately for supplies. The Secretary of HHS recently announced that Operation Restore Trust will be expanded to 12 additional states.

HCFA also sponsored pilot projects as part of a "Home Health Initiative" that assessed the extent to which the detection of abusive billing can be fostered by educating beneficiaries about home health coverage and eligibility and by formally notifying beneficiaries and physicians of benefits provided.

[4]State certification surveys generally do not look at coverage and eligibility issues, although state surveyors can identify patients who are not homebound and services and supplies that are billed but not provided.

Medicare's Existing Safeguard Apparatus Presents Opportunity to Exercise Greater Accountability

HCFA's education initiatives may improve beneficiary and physician awareness of improper billing practices, but HCFA needs to hold home health agencies more directly accountable for submitting proper claims. In the past, when seeking recovery of inappropriate payments, intermediaries have used two approaches to assess overpayment amounts. One is to audit a universe of claims submitted by the provider and total the charges disallowed. However, the large volume of claims submitted by the average provider and the time involved in reviewing a claim make this approach impractical in most cases. The second approach is to audit a statistically valid sample of the provider's claims and estimate total charges disallowed by projecting the sampling results. Because of the scarcity of funds to audit claims, it has been difficult to pursue either approach in recent years.

Currently, Medicare's intermediaries are responsible for focusing medical reviews on claims from home health agencies that seem likely to be billing inappropriately.[5] Given the funding provided under HIPAA, the expectation is that HCFA will be better able to carry out these focused medical reviews. However, this funding may not be sufficient to do the follow-up audit work required once improper billing identifies an agency as an abusive biller and to conduct enough focused reviews for other home health agencies also deemed likely to be billing improperly. Consequently, Medicare would be prevented from taking the steps necessary to recover a greater proportion of payments that have been made inappropriately.

One option to help finance Medicare's audits of claims would be to assess home health agencies that are found to be abusive billers for the costs of performing follow-up audit work. The home health agency could choose whether to have a review based on the universe of its claims for a particular period or a statistically valid sample. HCFA would estimate the costs and withhold some percentage of the agency's current Medicare payments, unless the agency negotiated an alternative payment method, to ensure that the audit costs (as well as any assessed overpayment) could be recovered from the agency. By earmarking monies from the assessed audit costs for payment safeguard activities, performing such claims audits could be made financially feasible for HCFA. (Under current law, such assessments would be returned to the general Treasury.)

[5]Under sec. 202 of HIPAA, the HHS Secretary is authorized to enter into contracts with additional entities to perform payment safeguard activities. Such activities would include, for example, medical reviews on claims from home health agencies that seem likely to be billing inappropriately. This authority became effective Aug. 21, 1996, but HCFA has not yet entered into any contracts of this type.

This option, which would require authorizing legislation, would build on HCFA's existing safeguard apparatus and should enable it to broaden its claims reviews. The approach, which could be piloted in one or more regions, would also require HCFA to establish procedures for identifying abusive billers that would be required to reimburse HCFA for the costs of additional claims reviews.

Conclusions

Given the rapid growth in Medicare home health spending, the importance of careful vigilance over payments for this benefit cannot be overstated. Some home health agencies continue to abuse the Medicare benefit by providing services that do not meet program coverage requirements or are not medically necessary. Limited oversight by HCFA allows abusive billings from these home health agencies to go undetected.

Recent federal antifraud efforts illustrate the value of effective claims oversight. Building on its current oversight efforts, HCFA could implement an enforcement mechanism that would hold home health providers accountable for meeting their responsibilities to provide beneficiaries with only necessary and appropriate covered services. Such a mechanism would include a means to recover from abusive billers some of HCFA's costs in conducting this oversight. This approach would not only help finance claims audits but also help deter further abusive billing.

Matters for Consideration by the Congress

To hold home health agencies more directly accountable for billing Medicare appropriately, the Congress may wish to consider enacting legislation directing HCFA to carry out a pilot demonstration to address the issue of abusive billing practices by home health agencies. Under such a demonstration, once improper billing has been detected that identifies an agency as an abusive biller, follow-up audit work would be conducted and the cost of this follow-up work would be assessed against the home health agency. To make such claims audits financially feasible, the Congress may wish to earmark monies from the assessed audit costs for HCFA's payment safeguard activities.

Agency Comments

On June 11, 1997, HCFA officials provided us with comments on a draft of this report. Those officials agreed that the concept presented in our report could be effective. On the basis of our discussion, it appears that this concept would fit well with HCFA's current efforts to strengthen program safeguards on the home health and skilled nursing facility benefits. They

noted that a number of details would need to be worked out to increase the likelihood that the demonstration project would be successful.

As arranged with your office, unless you announce its contents earlier, we plan no further distribution of this report until 10 days after the date of this letter. At that time, we will send copies of this report to the Secretary and the Inspector General of HHS, the Administrator of HCFA, and other interested parties. We also will make copies available to others upon request.

If you or your staff have any questions, please call me on (202) 512-6806 or William Scanlon, Director of our Health Financing and Systems issue area, at (202) 512-4561. Other major contributors to this report include Leslie Aronovitz, Lisanne Bradley, Marco Gomez, Sam Mattes, Barry Tice, and Don Walthall.

Sincerely yours,

Richard L. Hembra
Assistant Comptroller General

Appendix I

Scope and Methodology

To examine and compare Medicare controls over the home health benefit with those used by private insurers and to identify Medicare initiatives associated with appropriate payments for home health services, we reviewed information obtained from officials at HCFA headquarters, its San Francisco regional office, and the regional home health intermediaries responsible for paying Medicare home health claims.

We also reviewed information obtained from officials at the Office of Personnel Management (OPM), which administers the Federal Employees Health Benefits Program; five private health plans under contract with OPM to provide health care services;[6] and three private companies that perform utilization review and case management for private health plans. Additionally, we reviewed relevant GAO, HHS Office of the Inspector General, Operation Restore Trust, and intermediary reports on controls over the use of Medicare's home health benefit. We also reviewed manuals and criteria HCFA and private insurers use to administer and control the home health benefit.

To gain insight into Medicare controls over the home health benefit, we visited two judgmentally selected home health intermediaries: Blue Cross of California and Palmetto Government Benefits Administrators. To supplement work performed at these locations and to broaden our areas of analysis, we obtained additional information on home health claims and controls from the remaining home health intermediaries.

In addition, to determine whether the records supported the need for services or items billed to Medicare, we requested that one intermediary—Blue Cross of California—review the medical records, an itemized list of supplies, and other documentation for 80 high-dollar claims. The intermediary requested this supporting documentation from 26 home health agencies. We limited our request to 80 claims so that we would not overburden the intermediary's normal workload.

To select the 80 claims to be reviewed, the intermediary identified the universe of home health claims processed from May 1 to May 31, 1995. From this universe, the intermediary identified the top 10 providers in terms of dollars billed, per beneficiary, for specific home health benefit categories (medical supplies, surgical dressings, physical therapy, and skilled nursing). For each of these providers, the 20 largest claims in terms of dollars billed per service category were identified. From the specific

[6]The five private plans are the Blue Cross and Blue Shield Service Benefit Plan, Mail Handlers, Government Employees Hospital Association, National Association of Letter Carriers, and the American Postal Workers Union plans.

service categories, we judgmentally selected 80 claims. In selecting the 80 claims for intermediary review, we considered information on total charges, average per-day charge, total days charged, and diagnosis.

For each selected claim, the intermediary reviewed the total charges for all services on the claim. Consequently, even though we did not specifically select any claims for four types of home health services (speech therapy, occupational therapy, medical social worker, and home health aide), many of our selected claims had these services. Therefore, the intermediary also reviewed the appropriateness of these services.

We performed our work between January 1996 and June 1997 in accordance with generally accepted government auditing standards.

GAO Related Products

Medicare Post-Acute Care: Cost Growth and Proposals to Manage It Through Prospective Payment and Other Controls (GAO/T-HEHS-97-106, Apr. 9, 1997).

Medicare: Home Health Utilization Expands While Program Controls Deteriorate (GAO/HEHS-96-16, Mar. 27, 1996).

Medicare: Home Health Cost Growth and Administration's Proposal for Prospective Payment (GAO/T-HEHS-97-92, Mar. 5, 1997).

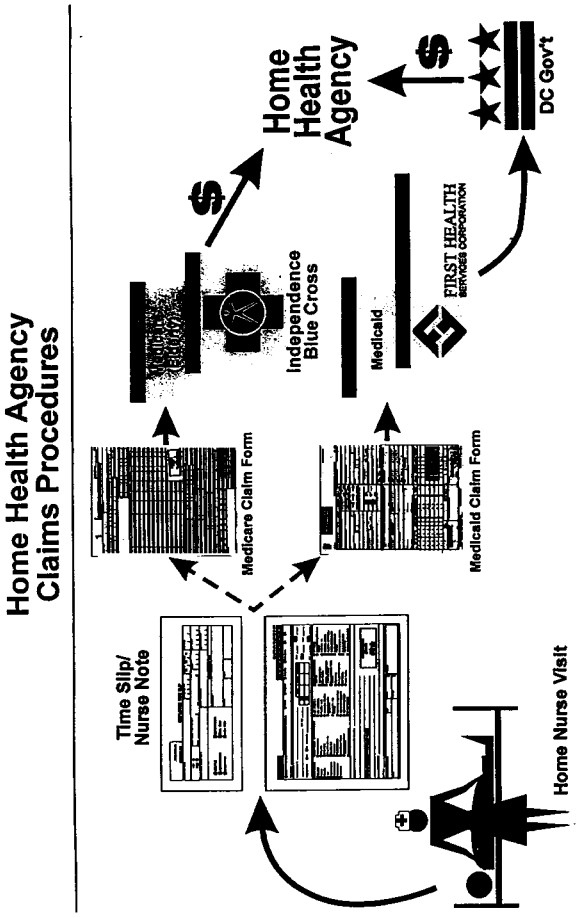
Medicare Post-Acute Care: Home Health and Skilled Nursing Facility Cost Growth and Proposals for Prospective Payment (GAO/T-HEHS-97-90, Mar. 4, 1997).

Exhibit:

Office of Inspector General Oral Testimony

Example with chart showing unsupported home health services claims:

> Services Not Rendered. The co-owner of a Washington, D.C. HHA was sentenced to 27 months in prison and ordered to pay full restitution of $100,000 defrauded from the Medicare and Medicaid programs. The HHA billed for 1,450 skilled nursing visits for which there are neither time slips nor nurses' notes documenting the visits were made. It also billed for home nurse visits when patients were actually hospitalized. Another co-owner was also convicted but has been in "escape status" since leaving his detention center assignment.


Home Health Agency
Claims Procedures
Time Slip/
Nurse Note
Home Nurse Visit
Medicare Claim Form
Medicaid Claim Form
Independence
Blue Cross
Medicaid
FIRST HEALTH
SERVICES CORPORATION
$
Home
Health
Agency
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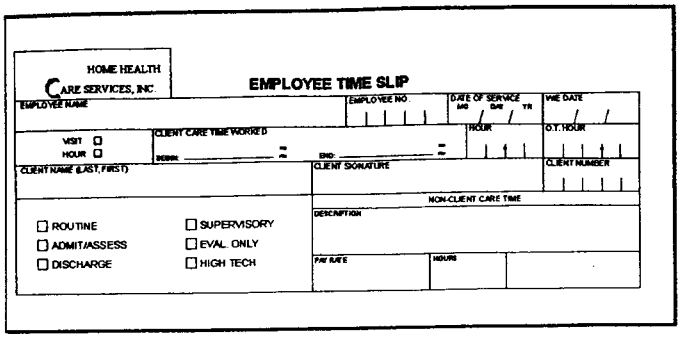
DC Gov't



HOME HEALTH CARE SERVICES, INC.

EMPLOYEE TIME SLIP

EMPLOYEE NAME | EMPLOYEE NO. | DATE OF SERVICE MO / DAY / YR | YHE DATE

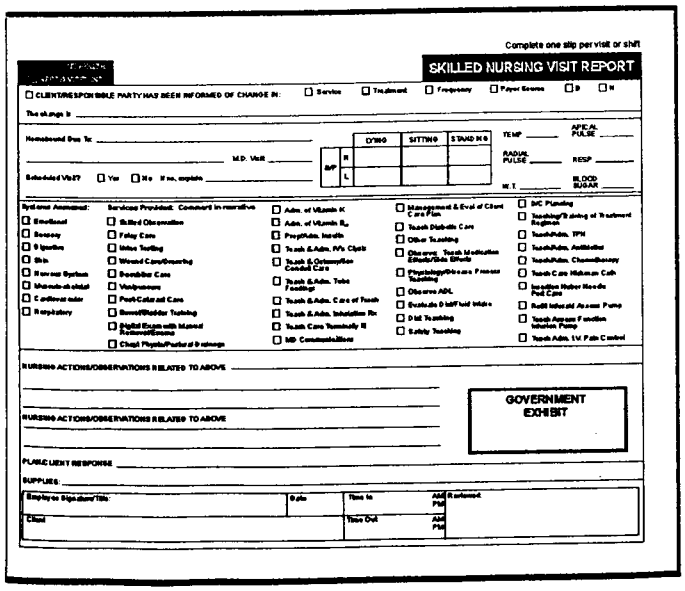
VISIT ☐ HOUR ☐ | CLIENT CARE TIME WORKED BEGIN: AM/PM END: AM/PM | HOUR | O.T. HOUR

CLIENT NAME (LAST, FIRST) | CLIENT SIGNATURE | CLIENT NUMBER

☐ ROUTINE ☐ SUPERVISORY
☐ ADMIT/ASSESS ☐ EVAL ONLY
☐ DISCHARGE ☐ HIGH TECH

NON-CLIENT CARE TIME

DESCRIPTION | PAY RATE | HOURS



Complete one slip per visit or shift

SKILLED NURSING VISIT REPORT

☐ CLIENT/RESPONSIBLE PARTY HAS BEEN INFORMED OF CHANGE IN: ☐ Service ☐ Treatment ☐ Frequency ☐ Payor Source ☐ D ☐ N

The change is _____

Homebound Due To: _____ M.D. Visit _____

Scheduled Visit? ☐ Yes ☐ No If no, explain _____

BP	LYING	SITTING	STANDING
R			
L			

TEMP _____ APICAL PULSE _____ RADIAL PULSE _____ RESP _____ WT _____ BLOOD SUGAR _____

System Assessed:
☐ Emotional
☐ Sensory
☐ Digestive
☐ Skin
☐ Nervous System
☐ Musculoskeletal
☐ Cardiovascular
☐ Respiratory

Services Provided: Comment in narrative
☐ Skilled Observation
☐ Foley Care
☐ Urine Testing
☐ Wound Care/Dressing
☐ Bowel/Bladder Care
☐ Post-Colostomy Care
☐ Bowel/Bladder Training
☐ Rectal Exam with Manual Removal/Enema
☐ Chest Physio/Postural Drainage
☐ Adm. of Vitamin K
☐ Adm. of Vitamin B12
☐ Prep/Adm. Insulin
☐ Teach & Adm. IV's Check
☐ Teach & Consumption Conduit Care
☐ Teach & Adm. Tube Feedings
☐ Teach & Adm. Care of Trach
☐ Teach & Adm. Inhalation Rx
☐ Teach Care Terminally Ill
☐ MD Communications
☐ Management & Eval of Client Care Plan
☐ Teach Diabetic Care
☐ Other Teaching
☐ Observe, Teach Medication Effects/Side Effects
☐ Physiology/Disease Process Teaching
☐ Observe ADL
☐ Evaluate Diet/Fluid Intake
☐ Diet Teaching
☐ Safety Teaching
☐ IHC Planning
☐ Teaching/Training of Treatment Regimen
☐ Teach/Adm. TPN
☐ Teach/Adm. Antibiotics
☐ Teach/Adm. Chemotherapy
☐ Teach Care Minimum Cath
☐ Ileostomy/Other Needs Post Care
☐ Refill Infusicil Access Pump
☐ Teach Access Function Infusion Pump
☐ Teach Adm. IV Pain Control

NURSING ACTIONS/OBSERVATIONS RELATED TO ABOVE _____

NURSING ACTIONS/OBSERVATIONS RELATED TO ABOVE _____

GOVERNMENT EXHIBIT

PLAN/CLIENT RESPONSE _____

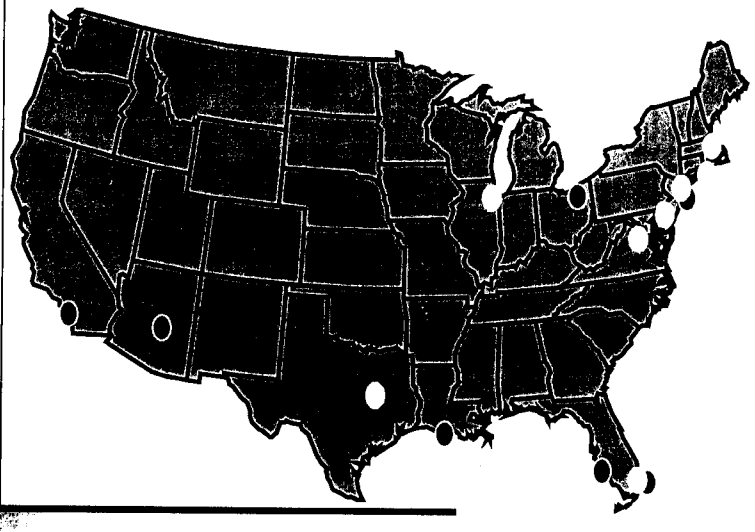
SUPPLIES: _____

Employee Signature/Title:	Date	Time In	AM/PM
Client		Time Out	AM/PM

Senate Permanent Subcommittee on Investigations
EXHIBIT # 5a

Federal Bureau of Investigation

Designated Health Care Squads



Existing
- Boston
- Chicago
- Dallas
- Miami
- Newark
- New Haven
- New York
- WFO

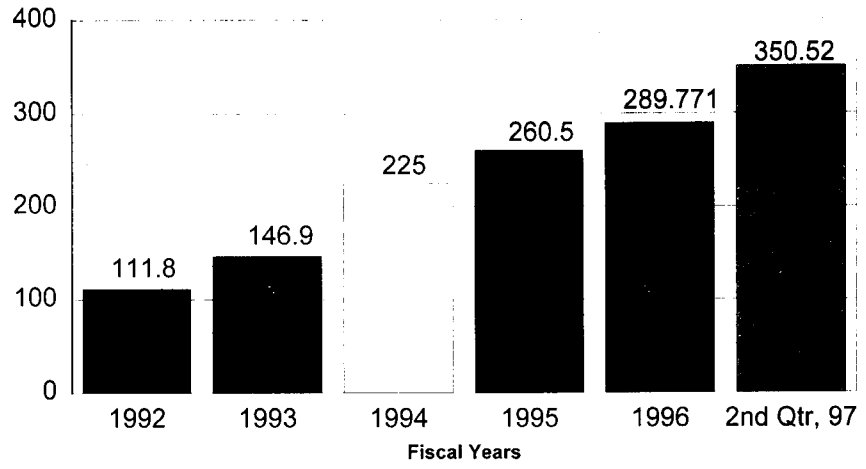
To be established
- Cleveland
- Los Angeles
- Miami(+)
- New Orleans
- New York (+)
- Phoenix
- Tampa

on Investigations

EXHIBIT # 5b

RESOURCE UTILIZATION

Health Care Fraud

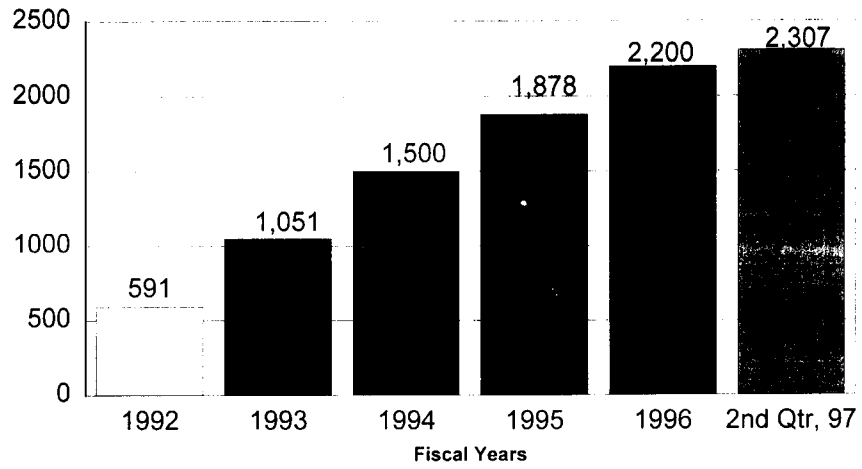


on Investigations

EXHIBIT # 5c

PENDING CASELOAD

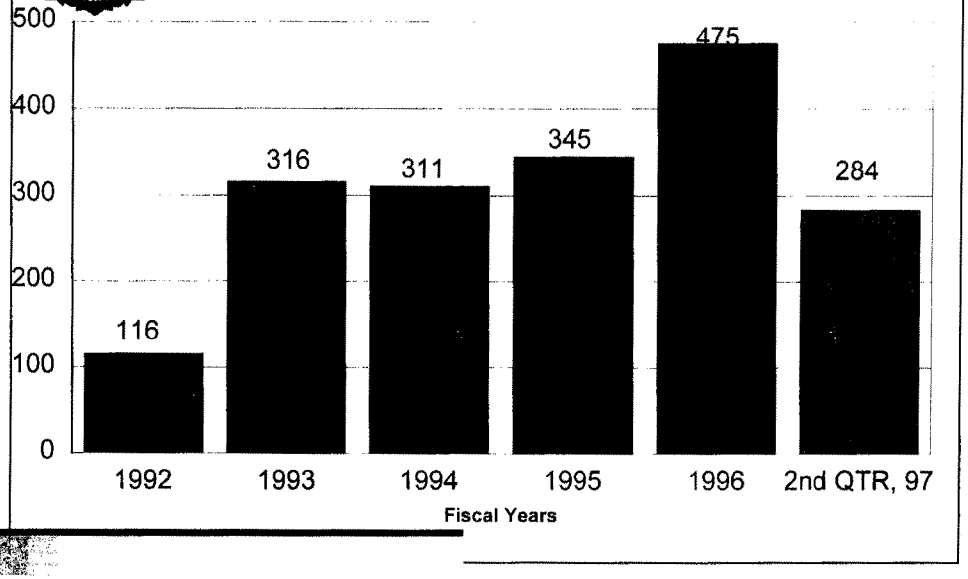
Health Care Fraud



Senate Permanent Subcommittee on Investigations
EXHIBIT # 5d

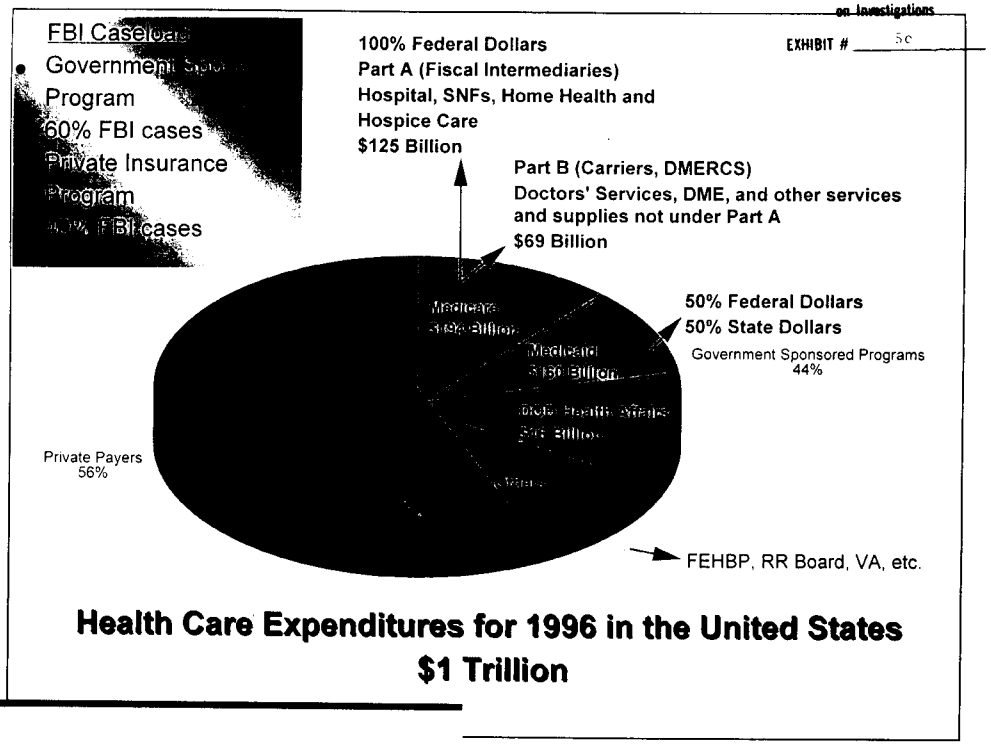
CONVICTIONS

Health Care Fraud



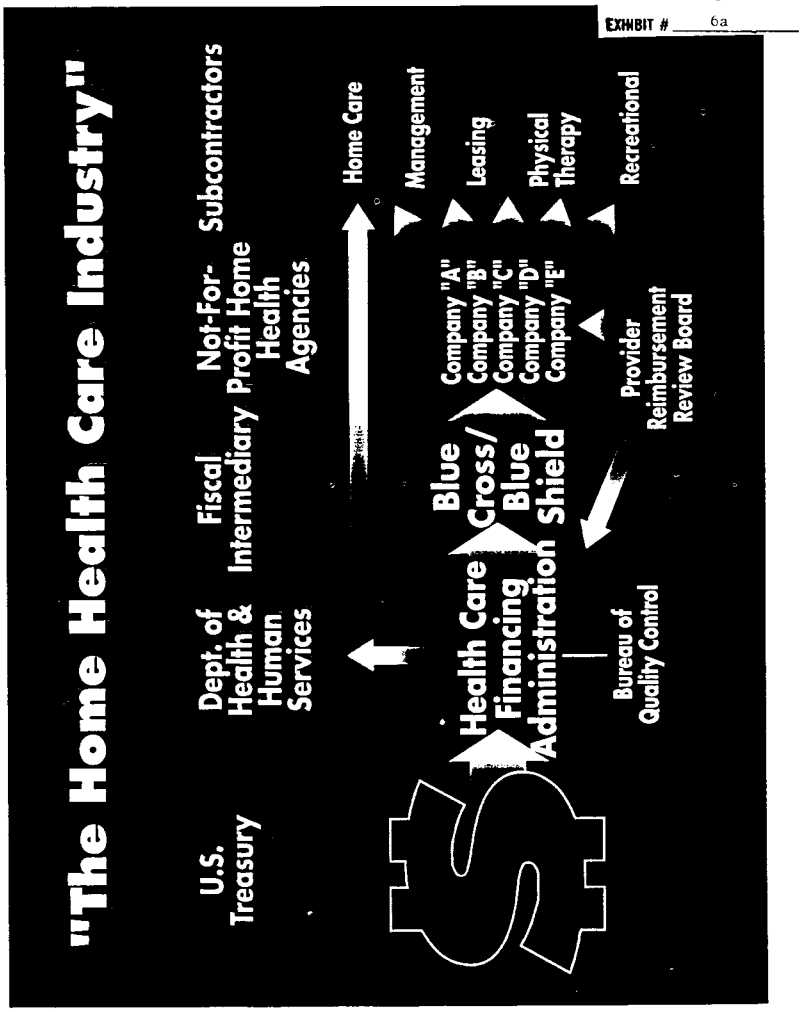
Senate Permanent Subcommittee on Investigations

EXHIBIT # 5c



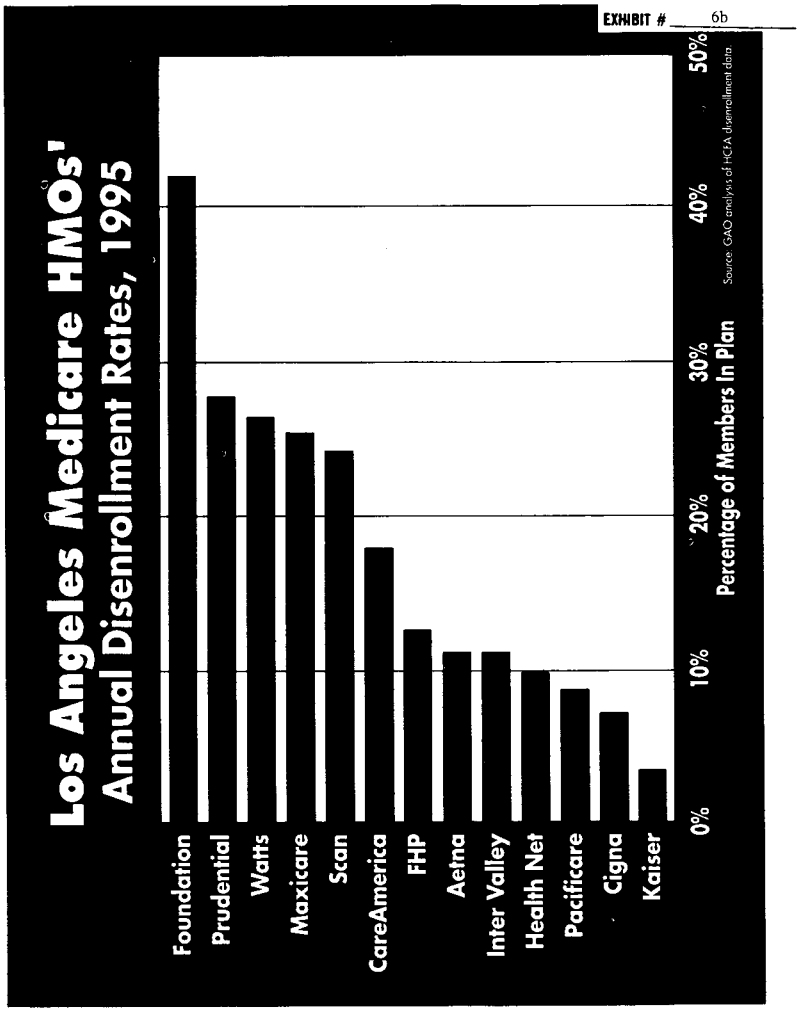
Health Care Expenditures for 1996 in the United States
$1 Trillion

Senate Permanent Subcommittee on Investigations
EXHIBIT # 6a



Senate Permanent Subcommitte on Investigations

EXHIBIT # 6b



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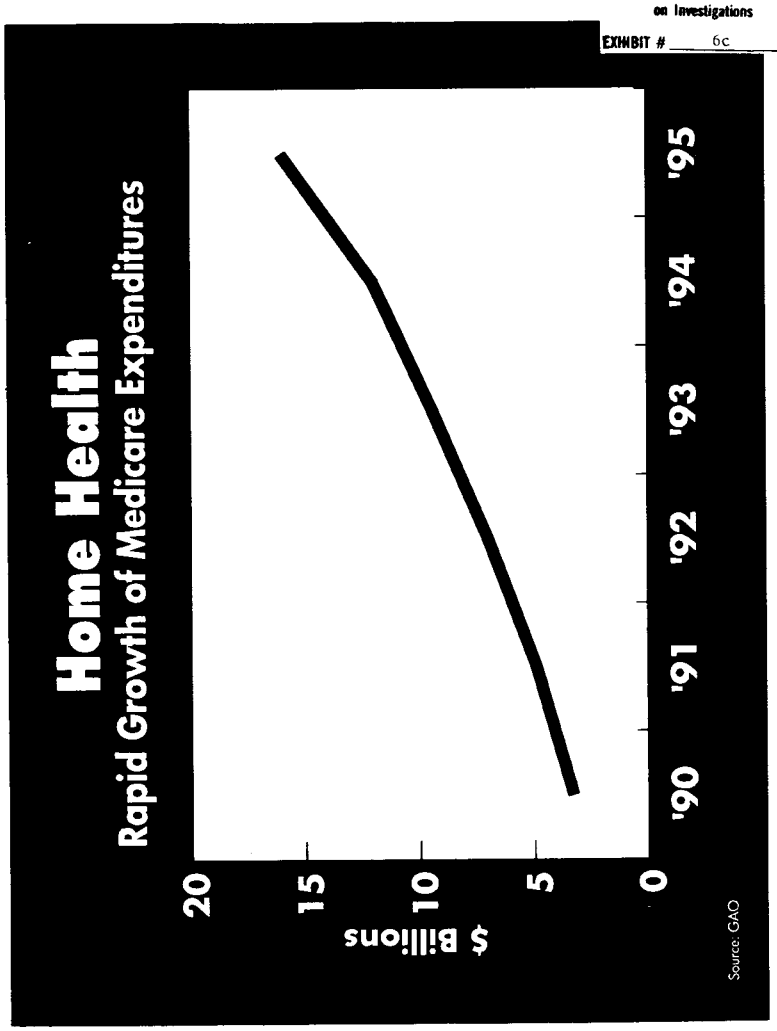

MEMORANDUM

June 19, 1997

TO: PERMANENT SUBCOMMITTEE ON INVESTIGATIONS
MEMBERSHIP LIAISONS

FROM: IAN SIMMONS, Counse
DON MULLINAX, Investigator
Permanent Subcommittee on Investigations

VIA: TIM SHEA, Chief Counsel/Staff Director
Permanent Subcommittee on Investigations

RE: PSI Overview Hearing on Health Care & Medicare Fraud

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I. Introduction

The Permanent Subcommittee on Investigations will hold an overview hearing on Wednesday, June 25, 1997 at 9:30 a.m. in SD-342 on health care fraud and abuse, with particular emphasis on the Medicare program. In a May 23, 1997 letter, the prospective witnesses were

apprised of the topics on which the Subcommittee would like to hear testimony. Those topics are:

1. Fraud and abuse in the home health care area, including weaknesses in the certification process of home health care providers;
2. The prevalence of up-coding in Medicare;
3. Problems in the durable medical equipment industry, such as the creation of artificial shortages of supply, and billing illegalities such as billing for services not delivered and unbundling;
4. Fraud and abuse in the nursing home industry;
5. Hospital billing of Medicare for outpatient tests done within 72 hours of an overnight admission;
6. Inflated reimbursement practices relating to oxygen and tube feeding supplies;
7. Billing abuses in the training of residents (the "elbow to elbow" rule);
8. Marketing abuses in the HMO industry; and
9. The adequacy of current criminal and civil enforcement measures.

Below, each issue is discussed in turn, with the animating purpose of underscoring the definition and breadth of the problems at hand rather than mapping out or suggesting their overarching solutions -- a tall order reserved for a later date. Indeed, by establishing as comprehensive a record as possible as to the *definition and seemingly systemic contributory causes* of Medicare fraud and abuse, the Subcommittee's overview hearing will provide an important framework and starting point for subsequent elaboration, investigation and, hopefully, constructive recommendations by way of a Subcommittee report.

The witnesses are: on panel 1, **Leslie Aronovitz**, Associate Director of Health Financing and Systems Issues at the GAO, a recognized expert in health care fraud issues; **Judy Berek**, senior Advisor for Program Integrity, Health Care Financing Administration, Department of Health and Human Services; and **Professor Pamela Bucy**, Bainbridge Professor of Law,

University of Alabama Law School, a well-known expert in the area and former Assistant United States Attorney. On panel 2: **Michael F. Mangano**, Principal Deputy Inspector General, Department of Health and Human Services and **Charles L. Owens**, Chief, Financial Crimes Section, Federal Bureau of Investigation.

Preliminarily, however, a brief overview is provided below of the health care industry in general and Medicare program in particular and the Subcommittee's involvement in both.

II. Overview

A. *The Medicare Program*: It is no overstatement to say that America's vital health care industry is an economic behemoth; by some estimates, combined private and public expenditures on health care constitute 13.6% of America's gross domestic product in 1995 dollars.[1] Indeed, according to 1995 data, national health care expenditures were at least $988.5 billion[2]; $350.1 was spent on hospital services, $28.6 billion on home health care services, $77.9 billion on nursing home services and $55.5 billion on prescription services. Total health care expenditures over the past five years has increased at an annual rate of 8%.[3] This rate of increase is not surprising nor is it likely to abate, as the country's population demographics continue to change with the greying of America.

The nation's largest health payer is a public one, the Medicare program. Regrettably, from 1992 to the present, the Medicare program has borne the dubious distinction of being on the GAO's list of government programs "highly vulnerable to waste, fraud, abuse and

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[1] *Economic and Budget Outlook: Fiscal Years 1998-2007*, Congressional Budget Office, January 1997, table H-1 at 126.

[2] Katherine R. Levit, *et al.*, "National Health Expenditures, 1995" in *Health Care Financing Review*, Vol. 18, no.1 (Fall 1996) at 199.

[3] *Id.*

mismanagement." The GAO has concluded that although the Health Care Financing Administration ("HCFA") "has made some regulatory and administrative changes aimed at curbing fraudulent and unnecessary payments", in recent years, "sizable cuts in the budget for program safeguards . . . have diminished efforts to thwart improper billing practices."[4]

Medicare, authorized under Title XVIII of the Social Security Act of 1965, provides health insurance for over 38 million people aged 65 years and over, as well as certain disabled individuals. Gross Medicare outlays in FY 1998 are estimated at $230.1 billion.[5] In FY 1996, total Medicare outlays were $194.3 billion ($174.2 billion, net). Net Medicare outlays have doubled between 1990 and 1998.[6] The GAO believes that at least 5-10% of total Medicare expenditures arise from fraudulent or abusive conduct.[7] Indeed, one recent *Wall Street Journal* article cities an unpublished HHS Inspector General's report as estimating that improper payments to health care providers accounted for 12% of the 1996 Medicare budget. *See The Wall Street Journal*, "Estimate of Improper Medicare Costs Soars" (June 11, 1997) at A2-A4. Based on net FY 1998 Medicare outlays, then, up to $23 billion may be lost to fraud and abuse on an annual basis. Recouping or deterring that loss through vigilant and heightened enforcement may blunt or render a wash expected cuts in the annual growth of the Medicare program. *See CQ Monitor*, Vol. 33, No. 89 (June 5, 1997) at 2 (reporting that the House Ways and Means Health

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[4] The GAO also concludes: "Problems in funding program safeguards and HCFA's limited oversight of contractors continue to contribute to fee-for-service program losses. While HCFA expects a major system acquisition project to reduce certain weaknesses, the project itself has several risks that may keep HCFA from attaining its goals. In addition, the managed care program suffers from excessive payment rates to HMOs and weak HCFA oversight of the HMOs it contracts with. These flaws leave beneficiaries without information essential to guide their HMO selection and without assurance that HMOs are adequately screened and disciplined for acceptable care." GAO High Risk Series, *Medicare* (February 1997) at 8.

[5] Net Medicare outlays (after deduction of beneficiary premiums) are estimated at $208.6 billion. *See* CRS Report for Congress: *Medicare: FY 1998 Budget* (updated April 15, 1997) at 3.

[6] Net Medicare outlays were $159.9 billion in 1995; $144.7 billion in 1994; $130.5 billion in 1993; $119 billion in 1992; $105 billion in 1991 and $98.1 billion in 1990.

[7] Most Medicare services are provided through the fee-for-service sector, where any qualified provider can bill the program for each covered service rendered. In recent years, greater numbers of Medicare beneficiaries have enrolled in HMOs to receive covered services. However, the GAO estimates that at least 90 percent of beneficiaries remain under the fee-for-service program.

Subcommittee unanimously approved changes in the Medicare system that would expand seniors' options for health care while "trimming the growth of federal spending on the program by $115 billion over the next five years.")

Medicare is the second largest social welfare program in the federal budget, exceeded only by the Social Security program. Almost one million providers serve beneficiaries and bill Medicare on a fee-for-service basis. This includes over 29,000 hospitals, skilled nursing facilities, home health agencies, and hospices, about 160,000 laboratories, 140,000 suppliers and almost 700,000 physicians. The claims filed with the Medicare program are received, reviewed processed and paid by insurance companies under contract to the Medicare program. Medicare has over 70 insurance companies, who use 8 different standard claims processing systems, although a unified claims processing system was to begin operating in 1997. (Claims submitted to the Medicaid program are processed by each state). Thus, HCFA's efforts to guard against inappropriate payments largely have been contractor-managed operations, permitting the carriers and fiscal intermediaries broad discretion in acting to protect Medicare's integrity. But there are significant variations in contractors' implementation of Medicare's payment safeguard policies. In 1996, the budget for contractors to administer Medicare was approximately $1.6 billion, with 24 percent devoted to payment safeguard activities. *See* GAO: High Risk Series: *Medicare* (February 1997) at 13.[8]

Moreover, since October 1994, HCFA has revoked nearly 1500 billing numbers, resulting in savings of over $7 million per month. (Apparently, the majority of these revocations were in the South Florida area).

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[8] According to its April 1996 statement on *Fraud and Abuse Activities*, HCFA states that it:

> ...has focused special attention upon assuring the careful enrollment of these providers and suppliers. For example, the National Supplier Clearinghouse ("NSC") which monitors supplier enrollment, has established a national file on the nation's 140,000 DME suppliers. Using the file, NSC checks, among other things, whether applicants for supplier numbers have been sanctioned by the Inspector General. NSC also maintains a bank of information on related businesses of owners and on managing employees whose names are linked to multiple suppliers.

Medicare consists of two parts:

Part A provides premium-free coverage of the costs involved with *hospitalization and certain follow-up services* for individuals aged 65 years and over, as well as certain disabled persons. Part A also provides up to 100 day coverage of post-hospital skilled nursing facility care ("SNF"), home health services and hospice care.[9] There currently are no cost-sharing requirements for home health care and limited charges for hospice care. The Part A program is financed primarily through payroll taxes levied on current workers and their employers. Income from these taxes is credited to the Hospital Insurance trust fund maintained by the Department of the Treasury.

Part B, which is financed through a combination of beneficiary premiums (25%) and general revenues, is a *supplementary medical insurance program covering physician services and related services and supplies*. Specifically, Part B provides coverage for a complementary set of health services including physicians' services, laboratory services, durable medical equipment, outpatient hospital services and other medical services. Beneficiaries are subject to cost-sharing charges for most services under Part B. That is, the program generally pays 80% of Medicare's fee schedule or other approved payment amount after the beneficiary has met the annual $100 deductible. The beneficiary generally is liable for the remaining 20%.

In essence, in lieu of a massive public sector bureaucracy, HCFA administers Medicare largely through an administrative structure of claims processing contractors. Under the Medicare Program, insurance companies -- like Blue Cross and Blue Shield, Travelers, and Aetna -- process and pay claims because of their expertise in performing these functions. As Medicare contractors, these companies use federal funds to pay health care providers and beneficiaries and are then reimbursed for their administrative expenses incurred in performing the work. Generally, ***intermediaries*** are the contractors that handle *Part A* claims submitted by institutional providers (*viz.*, hospitals, skilled nursing facilities, hospices and home health agencies) and ***carriers*** are

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[9] Patients must pay a deductible ($760 in 1997) for each hospital admission that begins a benefit period.

those handling *part B* claims (*viz.*, physicians, laboratories, equipment supplier, and other practitioners). Over the years, HCFA has consolidated Medicare operations and the number of contractors has fallen from about 130 to 70 in 1996, who together processed over 800 million claims in 1996. *See* GAO High Risk Series, *Medicare* (February 1997) at 15. This represents a *70% increase over the 1989 claim volume*; during that same period, however, resources committed to claims review grew by less than 11 percent. *Id.* at 16.

As of February 1996, the HHS Inspector General had excluded 8,830 providers from federal health care programs nationwide. Three exclusion categories -- conviction for program-related crime, conviction for patient abuse or neglect, and license suspensions and revocations -- accounted for 76 percent of these nationwide exclusions.[10]

B. *The Health Insurance Portability and Accountability Act*: Recent legislation -- Title II of the Health Insurance Portability and Accountability Act, Public Law 104-191 (the "Kassebaum-Kennedy" Act, which is based on legislation introduced by Senator Cohen) -- added new criminal health care fraud provisions, strengthened existing civil and criminal fraud and abuse provisions, and increased funding for new anti-fraud programs directed both at federal and private health care programs (though, as the GAO notes, Medicare safeguard funding, assessed on a per claim basis, remains below 1989 levels, adjusted for inflation). *See* GAO High Risk Series, *Medicare* (February 1997) at 9. Title II adds new civil monetary penalties for fraudulent practices such as "up coding" and billing for unnecessary services (sections 204, 231); it increases certain Medicare and Medicaid program civil and criminal penalties, including raising most civil

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[10] HCFA has taken an important step to reduce Medicare's vulnerability to abusive billing and prevent fraudulent or excluded providers from continuing to bill the program. In May 1996, HCFA extended its existing system of physician identification numbers and registration procedures to new Medicare providers and suppliers. Medicare contractors are now required to verify professional and business license, certification, and registration information and billing agency and subcontractor agreements. Contractors must also check each owning and managing employee against the HHS Inspector General's list of currently sanctioned providers and suppliers. GAO has identified problems with the completeness of this list, but believes if corrected, it could preclude fraudulent and incompetent providers from billing Medicare. As of February 1997, HCFA was to assign new identification numbers (National Provider Identifiers) to every provider and supplier in the Medicare program and will require the use of these numbers for billing purposes. The numbers will be unique to each provider or supplier and will stay with them as long as they participate in the Medicare program, regardless of relocations or changes in medical specialities.

monetary penalties from $2,000 to $10,000 per violation (*id.*); it extends certain Medicare and Medicaid fraud and abuse provisions to other federal health care programs (section 202). The Act also adds new health care fraud criminal provisions to Title 18 of the United States Code (section 217, criminalizing the disposition of assets in order to obtain benefits) and a new civil monetary penalty for physicians who falsely certify that an individual meets Medicare home health care requirements.

Additionally, Title II establishes several new health care fraud initiatives including: (1) a Medicare Integrity Program authorizing contracts with private entities to carry out Medicare program audits (section 202) and utilization reviews and fraud reviews; (2) a new beneficiary incentive program to encourage individuals to report violations of Medicare and Medicaid fraud and abuse laws (section 203); (3) a fraud and abuse control program to coordinate federal, state and local law enforcement efforts against fraud in federal and private health care programs; and, (4) a health care fraud and abuse data collection program (section 201). The legislation also established a Health Care fraud and abuse expenditure account within the Medicare trust fund. Monies derived from the coordinated anti-fraud and abuse program from the imposition of fines and forfeitures, are to be transferred to this account from the Treasury and used to fund this anti-fraud effort.

With the passage of the Kassebaum-Kennedy "insurance portability" legislation, the bill greatly increased federal funding for health-fraud enforcement: various anti-fraud units are getting $104 million from Medicare this year and the amount will jump to more than $200 million a year by 2002. Finally, Section 205 of the Act requires HHS, in consultation with the Attorney General, to issue written advisory opinions as to whether, *inter alia*, an activity or proposed activity constitutes grounds for the imposition of criminal or civil sanctions.

The fee-for-service program covers most of Medicare's beneficiaries -- almost 90% or 33 million individuals in 1996. Medicare's managed care program covers a much smaller number of beneficiaries -- nearly 5 million in 1996, which fall into *two* categories both of which are funded from the part A and B trust funds. The first category consists of *risk contract HMOs*

(comprising the bulk of managed care Medicare beneficiaries, 4 million). Here, physicians, hospitals, and other providers serving these HMOs' enrollees do not submit a per-service claim for reimbursement. Instead, they are paid by the HMO, which in turn is paid a monthly amount by Medicare for each beneficiary enrolled. This amount is fixed in advance. In this sense, the HMO has a "risk" contract because regardless of what it spends for each enrollee's care, the HMO assumes the financial risk of providing health care within a fixed budget. HMOs profit if their cost of providing services is lower than the predetermined payment but lose if their cost is higher than the payment.

The second category of managed care includes *cost contracts and health care prepayment plans*. Cost contract HMOs allow beneficiaries to choose health services from an HMO network or outside providers. Health care prepayment plans may cover only part B services. Together, they enroll fewer than 2 percent of the Medicare population. *See* GAO High Risk Series: *Medicare* (February 1997) at 14 & n.2.

Some have suggested that the health system's moves to managed care arrangements will reduce the incentives and opportunities to commit fraud that exist under the fee-for-service system. However, a recent analysis suggests that although the types of fraudulent activities may change, substantial opportunities for fraud and abuse will remain. Under a capitation system (where a fixed monthly payment is made per enrollee) dishonest providers could falsify reports of patient encounters, treatment outcomes, and costs in attempts to disguise under-treatments and thereby seek artificially to inflate future capitation payments. Dishonest providers also may record false enrollments in managed care plans funded by government programs.[11]

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[11] The IG reported that over the 1984-1995 period, 7,795 individuals and 788 entities were excluded from the Medicare and Medicaid programs. As of June 1995, 7202 had not been reinstated, 1,355 were fully reinstated and 46 were classified as repeat offenders.

During the six-month period from April-September 1996, the IG imposed 1,151 sanctions in the form of exclusions or monetary penalties against individuals and entities that engaged in fraud and abuse of Medicare and Medicaid. About three quarters of the exclusions were based on conviction of program related crimes, conviction of controlled substance manufacture or distribution, conviction related to patient abuse or loss of license to practice. During this period, the government recouped $94 million through both the civil money penalty provisions and the False Claims civil settlements relating to health care.

To be sure, the federal effort to combat Health care fraud has generated headline news. One May 1997 *Wall Street Journal* article quotes the head of the FBI's financial crimes unit, Charles Owens, as stating that "[w]e've seen escalating losses in the government's health programs. It's time to turn the tide." The FBI now has 350 agents investigating the medical industry, up from 290 last October, with a caseload of over 2,300. And, over the years, the Subcommittee has had -- as former Subcommittee Chairman Roth said -- "...a longstanding interest in issues involving waste, fraud and abuse in our Nation's health care system...." In February 1996, the Subcommittee held hearings on *Improper Medical Billings by Hospitals Nationwide for Investigational Devices and Procedures*; in 1994, it held hearings on and in 1995 issued a Report on fraud and abuse in certain Blue Cross/Blue Shield plans; in 1992 it published a report based on an 18 month investigation and five hearings into fraud in the insurance industry, particularly fraud in multi-employer sponsored health plans (which concluded that "a class of insurance comment . . . bilk unsuspecting employers and employees of millions of dollars, leaving tens of thousands of working people with worthless insurance, unpaid medical bills, and in many instances, an inability to obtain future health care coverage"); in June and July 1990 the Subcommittee held hearings on fraud and abuse in Medicare's secondary payer program; and, in a prescient hearing and report, in 1981, the Subcommittee examined the problem of extensive fraud in the home health care industry. Also, in 1976 the Subcommittee's work exposed rampant fraud in the CHAMPUS program.

III. Fraud And Abuse: High Risk Industries & Practices

A. *The Home Health Care Industry*: Medicare's home health care outlays have tripled over the past five years to over $22 billion. *See Wall Street Journal* (May 7, 1997). However, according to its March 1996 report, the GAO contends that "[c]ontrols over the Medicare home health benefit remain essentially nonexistent . . . [f]ew home health claims are subject to medical review and most claims are paid without question." Indeed, Bruce Vladeck, administrator of HCFA, told a House Subcommittee in March 1997 that about *one-fourth* of home health claims

may be spurious. *See The Chattanooga Times* (March 27, 1997) at A9.[12] And the GAO has concluded that most claims are paid without question. This is ironic, for the theory of home care was that money would be saved by keeping people out of more expensive hospitals and nursing homes. However, because agencies are paid for each visit they make and for as many as they make, this gives them an incentive to continue care, regardless as to whether it's needed. Although physicians are supposed to approve treatment, they often do not check to see if it should continue. Indeed, some press accounts note that many physicians do not authorize treatment in the first place.

Medicare reimburses home health agencies on a retrospective cost-based basis. This means that agencies are paid *after services are delivered* for the reasonable costs (as defined by the program) they have incurred for the care they provide to program beneficiaries, up to certain limits. Cost-based reimbursement for home health has been criticized as providing few incentives for maximizing efficiency, minimizing costs, or controlling volume of services. It is cited as one of the reasons for the significant growth in home health spending since 1989. Spending has increased from $2.6 billion in 1989 to $18.1 billion in 1996, for an average annual rate of growth of 32%.[13]

In one 1995 investigation, the HHS-IG found that in a review of 100 claims (representing 2,068 home health services) 40 claims contained 846 services that did not meet Medicare guidelines. These included 25 percent of the claims for 466 services made to individuals who were not homebound; 8 percent of the claims for 200 services which were not reasonable or

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[12] In 1990 there were 5,656 home health agencies participating in Medicare; by 1996, there were more than 9,800, serving around 7 million people. In March 1997, the Administration proposed rules requiring agencies to conduct criminal background checks on home aides.

[13] Both Parts A and B of Medicare cover home health. Neither Part of the program applies deductibles or coinsurance to covered visits, and beneficiaries are entitled to an unlimited number of visits as long as they meet eligibility criteria. Section 1833(d) of Medicare law prohibits payments to be made under Part B for covered services to the extent that individuals are also covered under Part A for the same services. As a result, the comparatively few persons who have no Part A coverage are the only beneficiaries for whom payments are made under Part B.

necessary; 5 percent of the claims for 127 services not provided; and 2 percent of the claims for 53 services which physicians denied authorizing. Some other examples:

- One Florida home health care agency billed Medicare $84,000 for gourmet popcorn, $140,000 for an airplane, $14,000 in company logo emery boards and $5,000 to lease a BMW for the owner's son.

- In February 1996, Robert "Jack" Mills, CEO of ABC Home Health Services, Inc., one of the nation's largest home-health chains, was convicted for his participation in a large Medicare fraud case. Fraud examiners said that Mills billed Medicare for more than $14 million in false expenses, including jewelry and a luxury beach house.

- In another case, five people in California who allegedly were caring for relatives were paid government funds for nearly a year until it was discovered the relatives were already deceased. The care givers also were beneficiaries of other government programs.

- According to a *Chattanooga Times* story one Florida company (St. Johns Home Health Agency of Miami Lakes) billed Medicare $26 million for visits it never made. In fact, about 75 percent of the company's 1993 claims were for visits never made or for visits to people who were not homebound or on behalf of doctors who had not authorized the expense, as Medicare requires. *See Chattanooga Times* (March 27, 1997) at A9.

Indeed, the HHS-IG and GAO have determined that a number of home health entities are nothing more than shell companies that move from state to state, once law enforcement catches on to them. To date, HCFA has not devised an efficacious means of tracking those entities or the individuals that devise them. The root of the problem is that seemingly anyone who wants to become a 'home health care' provider can become so, as certification from HCFA appears very easy. This is clearly an area where HCFA needs to do a better job.

Some sensible national standards for all home-care agencies and individual practitioners could help to ensure that a home-care worker is trained to provide proper patient and elder care. Some states have no set guidelines regarding the qualifications necessary to start a home-care agency. However, other states are beginning to take action against home-care and elder fraud.

The Maine Department of Human Services, for instance, will be introducing proposed legislation on crimes against the elderly in an upcoming legislative session and is working with other state agencies to find and prosecute instances of elder abuse, neglect and exploitation. *See* "Home Care Fraud: The Emerging Epidemic", ***The White Paper*** (March/April 1997) at 43. Possible national standard legislation could include:

- Supporting legislation requiring licensure and criminal background checks and criminal background checks for all home-care workers. Rhode Island already has begun to combat elder fraud by requiring criminal background checks as a precondition of licensing home-care workers.
- Revising written documentation to more clearly state rules regarding home care under Medicare, Medicaid, and private insurance policies so that consumers are informed of any limitation in their home-care coverage.
- Exhorting consumers to create a safe home-care environment, to monitor carefully all home-care workers, and to safeguard all valuables and financial records.
- Supporting new laws requiring all consumers to have a financial interest in the payment of home-care services. This can be accomplished in several ways, such as setting a limit on the number of visits or having a co-payment system in which the consumer shares the cost of home care with the insurer.
- Requiring all home-care workers to sign time sheets that include arrival and departure times. These time sheets also should be signed by the consumer or their representative.
- Reimbursing home-care providers on a flat-fee basis and not a cost-plus system. A bid system also could be used to reduce costs by competition. ***Indeed, a prospective payment system for home health care may be part of the Reconciliation bill.***

A major two year effort launched by HHS in May 1995, known as *Operation Restore Trust* ("ORT"), focused on five states (California, Florida, Illinois, New York and Texas), which together account for 40 percent of Medicare beneficiaries. The project targeted three areas the IG has identified with systemic fraud: home health agencies, nursing homes and durable medical equipment suppliers. ORT coordinated enforcement activities by federal and state government

representatives and exposed the pervasiveness of fraud in the home health care industry. *See* CRS Report to Congress: ***Health Care Fraud: A Brief Summary of Law and Regulations*** (January 24, 1997) at 3-4.[14] Additionally, the IG and Department of Justice have established a pilot voluntary disclosure program by which home health and nursing home providers and suppliers in the five states may come forward with full disclosure of potential fraud and abuse, and, by doing so, minimize their exposure and avoid exclusion.

The Permanent Subcommittee on Investigations anticipated and exposed the skein of the home health care industry and its susceptibility to fraud. In fact, the Subcommittee's 1991 Report findings remain apposite. These include the finding:

- "...that the current retrospective cost reimbursement system, as it applies [to the home health industry] lends itself to fraud, waste and abuse. It provides no incentive for home health agencies to contain costs."
- "...intermediary audits provide the first line of defense against excessive and inflated costs."
- "...HCFA has failed to make adequate use of the authority provided it to terminate home health agencies or otherwise preclude individuals from participation in the home health care program."

B. *Up-Coding*: Under the Kassebaum-Kennedy Act, a number of changes were made to the Medicare and Medicaid civil monetary penalty provisions, generally found in Section 118A of the Social Security Act. These changes include: the Medicare and Medicaid program provisions providing for civil monetary penalties for specified fraudulent activities are made applicable to similar violations in other health care programs funded by the federal government, such as CHAMPUS. Civil monetary penalties are increased from $2,000 to $10,000 for each item or service involved. Two new violations are added to the list of prohibited practices. One

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[14] The IG reports that as of September 30, 1996, 49 criminal convictions, 44 civil actions and 38 indictments were obtained under the ORT operation and that 132 providers were excluded from Medicare and Medicaid and that more than $70 million in fines, recoveries and civil damages were obtained.

is for a practice called "up coding", whereby a provider engages in a pattern or practice of presenting a claim for an item or service based on a code that a person knows or should know will result in greater payments than appropriate, and the other involves the submission of a claim that a provider knows or should know is for a medical item or service which is not medically necessary. Also prohibited under the civil monetary penalty provisions are certain offers of remuneration to individuals eligible for Medicare or Medicaid to influence those individuals to order or receive items or services from a particular provider or supplier where the item or services are reimbursable under Medicare or Medicaid. Also amended is the definition of the level of intent associated with fraud violations punishable by civil monetary penalties. Under the new standard, similar to the False Claims Act, a person is subject to such penalties if the person "knowingly" presents a claim that the person "*knows or should know*" falls into one of the prohibited categories. Some recent examples of up coding and billing fraud include:

- In the largest criminal probe of health care by the Federal Government, in July 1994, NME -- the owner and operator of a national chain of hospitals -- settled criminal and civil health care fraud allegations. It agreed to pay $33 million (the largest ever imposed in a health care fraud case) and $324.2 million in civil damages and penalties for harm to Medicare and CHAMPUS. The investigation found that NME psychiatric hospitals paid kickbacks to doctors and others as incentive for referring patients to the hospitals. The investigation also found that the NME psychiatric hospitals performed unnecessary hospital admissions and treatments, hospitalized patients longer than necessary to exhaust insurance coverage, billed multiple times for the same service or for services not rendered and billed Medicare for the kickback payments.

- On September 19, 1996 Corning Clinical Laboratories in New Jersey and Unilab Corporation in California, agreed to pay $11 million to the Federal Government to settle allegations that they submitted false claims to Medicare and CHAMPUS. Under the agreement, Corning will pay the Government approximately $7 million and Unilab will pay the Government about $4 million. The settlement resolves a civil suit filed in the District of New Jersey that focused on numerous regional labs operated by Corning and Unilab across the country. An investigation found that from 1990 to 1993, Corning and Unilab submitted false claims by billing for additional hemoglobin indices whenever a doctor ordered a "complete blood count" or "retic count" even though the additional indices were not ordered by doctors and were not medically necessary.

- On November 21, 1996, the nation's largest clinical laboratory, Laboratory Corporation of America Holdings (LABCORP) agreed to pay a total of $187 million to resolve charges of making false claims. LABCORP was charged with charging for two types of cholesterol tests, when physicians were only calling for one. Doctors were led to believe there would be little or no additional cost for the extra tests while, unknown to the doctors, the laboratories billed the health care programs the full price for the extra tests.

- One of the nation's largest physician staffing companies, EmCare, which provides staffing and other services for emergency treatment at hospitals at various locations throughout the country, agreed on May 22, 1997 to pay the U.S. Government and various states $7.75 million to settle allegations that it overcharged several Federal health care programs millions of dollars. Those payments stemmed from false claims that EmCare's billing company, Emergency Physicians Billing Service, in submitting bills on behalf of EmCare for services provided at EmCare facilities, engaged in up coding, billed for the same services twice and billed for services not provided. The inflated billings were submitted to Medicare, Medicaid and CHAMPUS and private insurance companies.

- As reported in the May 30, 1997 *The Wall Street Journal*, a former manager of three Columbia/HCA Health care Corp. hospitals (a corporation that owns 343 hospitals) stated that the corporation has a "score card" that rated and ranked each hospital each month on nearly a dozen measures from the cost of supplies to number of surgeries. One index, allegedly prodded hospitals to inflate Medicare charges. Moreover, the article reports allegations by a former CEO of a Columbia hospital stating that "he was told to try to ensure that 100% of his Medicare patients were coded as having complications." At another Kentucky hospital, Lake Cumberland, CFO Marvin Mayfield said Columbia's Medicare complications goal was "97% or 98%". A few days later, Columbia produced other executives who denied the company set any goals for Medicare complications. Columbia's Southwest hospital in Louisville tracked, each month, what percentage of its Medicare cases had complications. In February and April of 1996, Southwest scored a perfect 100%; in other months it managed to claim complications in 95% to 98% of Medicare cases.

- In February 1997, SmithKline Beecham agreed to resolve charges of Medicare billing fraud by paying $325 million. Like the *Corning* case, SmithKline was alleged to have billed for tests that were not requested or performed, paying kickbacks to doctors in exchange for their Medicare business.

C. *Durable Medical Equipment*: As the HHS-IG concedes in its September 1996 Semiannual Report, "[t]he [Durable Medical Equipment] DME industry has consistently suffered from waves of fraudulent schemes in which Medicare or Medicaid is billed for equipment never delivered, higher-cost equipment than that actually delivered, totally unnecessary equipment or supplies, or equipment delivered in a different State from that billed in order to obtain higher reimbursement."[15] Admittedly, the DME industry is a lucrative one: Medicare's 1995 DME expenditures topped $3.1 billion and medigap policies or beneficiaries picked up another $900 million. One of the principal problems is that there is a wide variation between high and low end (e.g., catheters) DME products in HCFA's fee schedule, but that fee schedule is set on the *median* price and does not account sufficiently for variations in quality. The incentive for suppliers is to provide low-end products and charge median to high-end prices. This is a big problem because HCFA doesn't know what the patient is actually getting.

According to a November 1995 GAO Report entitled *FRAUD AND ABUSE: Medicare Continues to be Vulnerable to Exploitation by Unscrupulous Providers*:

> ...[c]ertain characteristics of the Medicare program and the way it is administered create a climate ripe for abuse by unscrupulous providers. For many supplies and services, Medicare reimbursement far exceeds market rates. And providers are allowed to participate in the program without sufficient examination of their qualifications and their business and professional practices.

In that same November 1995 report, the GAO stated that it repeatedly has emphasized "the importance of 'upstream' controls that avoid reimbursement for inappropriate or inflated claims for health care services and supplies. However, these controls will never supplant -- though they do reduce -- the need for enforcement of laws and regulations targeting abusive and fraudulent providers. These 'downstream' activities serve the dual purpose of punishment and deterrence."

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[15] Durable medical equipment, as the phrase connotes, are items that can withstand repeated use and include oxygen equipment, hospital beds, wheelchairs and other equipment that physicians prescribe for home use.

Among the factors contributing to the persistence of fraud and abuse in the DME area are: (1) the fact that Medicare continues *to pay above-market rates* for many services (which encourages oversupply) and (2) the fact that Medicare *does not adequately screen providers* for credibility. As to the first point, the GAO cites the following examples:

- Two officers of durable medical equipment companies in Florida each were excluded for 20 years after being convicted of participating in a scheme to defraud the Medicare program. The companies provided liquid nutritional supplements to Medicare beneficiaries who did not need them. In order to get paid by the Medicare program, the companies paid fees to several doctors to sign the certificates of medical necessity (CMNs) authorizing the supplements even though these doctors never examined the beneficiaries. Once the companies had the CMNs, they billed Medicare about $400 a month for nutritional supplements and $250 a month for tubal feedings. Exclusions were previously impose against others involved in this scheme, based on their convictions.

- Five clinical labs (to which Medicare paid over $15 million in 1992) have been under investigation since early 1993 for the alleged submission of false claims. The labs' mode of operation was to bill Medicare large sums over 6 to 9 months; whenever a lab received inquiries from Medicare, it went out of business.

- A Georgia Medicare DME contractor reported that the program authorized a company to bill the therapy services even though it had no salaried therapists and was essentially a storefront office operated by one clerical employee. The shell company billed Medicare for services provided to nursing home residents through two therapy agencies with which it subcontracted. The company's contractual relationship with the nursing home residents through two therapy agencies with which it subcontracted. The company's contractual relationship with the nursing home entitled it to add to its claim an 80-percent markup over what the company paid the therapy agencies. As a result, a company that appeared to exist solely for the purpose of billing Medicare added in 1 fiscal year about $135,000 in administrative charges to the costs of the therapy services.

- Another shell DME company GAO identified had no staff. Simply by creating a paper organization with no office space or employees, an entrepreneur added $170,000 to his Medicare reimbursements over a 6-month period. The entrepreneur simply reorganized his nursing home and therapy businesses so

that a large portion of his total administrative costs flowed through the shell company and could thus be allocated directly to Medicare.

Second, the GAO concluded that *abuses persist because of inadequate detection, pursuit and punishment of offenders*. Claims monitoring often fails to detect over-priced or over-utilized services. In fact, even where controls exist to signal billing aberrations, many cases simply are not investigated. As of 1995, less than *one quarter of one percent* of Medicare spending went toward checking for erroneous or unnecessary payments.[16] As part of HCFA's *Operation Restore Trust*, HCFA asked all contractors (*i.e.*, insurance companies that process claims) to screen claims that represent unusually high dollar/volume of services and is compiling a comprehensive collection of "common sense" edits to be installed in the contractors' processing systems.[17] This project apparently is on-going and it is unclear when it will be completed; they should be questioned on this issue.

Payments for medical supplies are made under either of Medicare's two parts. Part A medical supply claims (submitted by hospitals or other institutions such as nursing homes or home health agencies) are paid by 43 local fiscal intermediaries. Medical supply claims submitted by noninstitutional providers such as physicians or medical supply companies, are paid by carriers. Thus, the same supply can be billed to Medicare for an individual under *two completely different* payment systems, one for Part A and another for Part B. Under Part A, the payment is generally made on the basis of *reasonable costs*. Under Part B, the payment is made

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[16] The Secretary of the HHS has the authority to exclude health care providers from Medicare and has delegated this authority to the Inspector General. Program exclusion is mandatory following convictions for Medicare or Medicaid program-related crimes or for patient abuse and neglect. Under other conditions, the Inspector General can exercise judgment as to whether exclusion is appropriate. According to the GAO, very few companies or other entities are excluded from the program: over the past 10 years, 90 percent of the exclusions have targeted individuals. *See FRAUD AND ABUSE: Medicare Continues to Be Vulnerable to Exploitation by Unscrupulous Providers* (November 1995) at 11 n.14.

[17] Since it was initiated in March 1995, Operation Restore Trust has resulted in 49 criminal convictions, 44 civil actions and 38 indictments. Additionally, over 130 providers have been excluded and the IG has identified a total of more than $70 million in fines, recoveries, settlements and civil monetary penalties owed to the Federal Government.

using a *fee schedule* established by HCFA. Historically, Part B fraud and abuse have plagued Medicare, and HCFA recently has reformed its operations. In October 1993, acting under specific statutory authority (42 U.S.C.§ 1395m(a)(12)), HCFA consolidated Part B carrier claims processing responsibility for DME; prosthetics; orthotics; and medical supplies, including surgical dressings, from 32 local carriers to 4 regional carriers. These carriers commonly are referred to as DME regional carriers ("DMERCS"). Through the use of these specialized regional carriers, HCFA hopes to achieve greater efficiency and accuracy in claims processing and also to reduce the variations in payment and coverage policies. They should be questioned on whether, in fact, they have achieved greater efficiency. Additionally, all claims must now be submitted *to the carrier serving the area where the beneficiary resides*. This change was meant to eliminate the ability of suppliers to engage in carrier shopping. Previously, suppliers could simply establish an address -- often just a post office box -- in the area served by the carrier with the most generous reimbursement rates and coverage policies and submit all bills to that carrier, regardless of where the beneficiary lived.

Legislation introduced by Senator Cohen and signed into law in October 1994 reformed certain aspects of the Medicare DME payment system, including requiring suppliers of medical equipment to meet strict standards and disclosure requirements in order to obtain and renew provider numbers, so that inferior suppliers can be kept out of the system and detected more easily and prohibiting Medicare from issuing more than one billing number to a supplier (with limited exceptions). It would be interesting to know from HCFA and HHS IG as to whether, in light of these reforms, there has been a measurable and commensurate reduction in fraud and abuse.

The GAO found that Medicare contractors repeatedly process, without questioning, claims that later prove to be fraudulent or abusive. For example, as reported by the IG, Medicare paid:

- An estimated $20 million in claims for unneeded nutritional supplements and feeding kits;

- Approximately $5.2 million in claims for oxygen concentrators, nebulizers, medications, and tests either not needed or not delivered;
- Approximately $500,000 in claims for unneeded transcutaneous electrical nerve stimulators; and
- $7 million in claims for orthotic body jackets that should not have been paid.

According to one GAO report, "[f]iscal intermediaries pay medical supply claims without knowing specifically what they are being asked to pay for on behalf of beneficiaries. The claims submitted by providers have no detailed information that would allow fiscal intermediaries to assess the claims' reasonableness. This lack of detail exists because HCFA guidance allows providers to bill all medical supplies under 10 broad codes; billed items are not listed by type or amount." GAO Report: *Medicare: Excessive Payments for Medical Supplies Continue Despite Improvements* (August 1995) at 5. (For instance, equipment of disparate price and function as a $21,437 pacemaker and a 75 cent sterile sponge often are recorded under code number 270). The GAO concludes that "unless fiscal intermediaries identify these claims for review and request additional documentation before payment, they will pay for the claims without knowing what the specific purpose was or whether it was covered or medically necessary." *Id.*

In fact, during a one-month trial period, the GAO reached disturbing conclusions as to the extent of fraud and abuse in the medical supplies industry. During the trial, the GAO requested the fiscal intermediary to obtain the medical records and itemized list of supplies supporting 85 high-dollar medical supply claims submitted by 38 providers during the one-month period. All of these claims initially had been processed without any review. The results of the fiscal intermediary's subsequent review are as follows:

- 89% of the claims for which documentation was received and reviewed (42 of 47) should have been totally or partially denied.
- Almost 61% of the dollars billed for medical supplies should have been denied for various reasons, including, among others, the fact the items were not

medically necessary, or were items not covered by Medicare or covered as part of routine or administrative costs.

- 45% of the claims for which documentation was not returned was subsequently denied.

Additional examples of abuse include:

- At least four suppliers regularly billed Medicare for 30 or more drainage bottles per month for each beneficiary. This is 90 times more than the proposed standard of one bottle every 3 months. The number of drainage bottles billed by these suppliers was 79% of all bottles billed to the regional carrier.

- One supplier billed Medicare an average of nine urinary leg bags per beneficiary a month. For some beneficiaries, the supplier billed for one leg bag a day or 15 times more than the proposed standard of two leg bags a month. In total, this supplier billed Medicare for over 50,000 leg bags or 21 percent of all leg bags billed to the regional carrier over 15 months.

For certain DME items -- but not for surgical dressings and other medical supplies -- the Secretary of HHS may adjust prices that are inherently unreasonable. *See* 42 U.S.C. § 1395m(a)(10)(B). In these cases, the authority is very limited and involves a complex set of procedures that is very time consuming. For example, it took HCFA nearly 3 years to reduce the price it was paying for home blood glucose monitors from a nationwide range of $144 to $211 to $58.71, even though they were widely available for about $50 and, in some cases, provided free as a means of obtaining customers for the disposable items associated with this test equipment. Because of the time and resources involved, HCFA only uses this process for one item at a time.[18] Query as to whether HCFA has tabled any legislative proposals to reform the current system.

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[18] In its 1995 Report, the GAO recommended that the HHS Secretary direct the Administrator of HCFA to: (1) require that bills submitted to fiscal intermediaries itemize supplies; (2) develop and implement prepayment review policies as part of the process of implementing any new or expanded Medicare coverage; and (3) establish procedures to prevent duplicate payments by fiscal intermediaries and carriers. GAO Report: *Medicare: Excessive Payments for Medical Supplies Continue Despite Improvements* (August 1995) at 13.

D. *The Nursing Home Industry*: The HHS-IG's office often expresses its concern about fraud and abuse in the nursing home industry and for good reason: the opportunities for fraud are abundant because there are a multiplicity of providers who deliver services to captive beneficiaries, yet no single individual or institution is held responsible for managing the beneficiary's care and ensuring that only needed services are delivered. Indeed, many of the incentives run in quite the opposite direction.

Medicare Part A covers inpatient care in a hospital or skilled nursing facility and home health or hospice care. The care in skilled nursing facilities that Part A covers -- for which Medicare paid an estimated $11.3 billion in 1996 (up from $6.6 billion in 1995) -- is limited to relatively short stays (up to 100 days) for patients who need daily skilled care following hospitalization. Most elderly people in nursing facilities do not qualify for Part A coverage. Although the resident may be paying for the nursing home, Medicare Part B covers critical ancillary services and supplies such as physician services, outpatient hospital services, durable medical equipment, and various other health services. Although the vast majority of Medicare patients in nursing facilities do not require skilled nursing care, they are entitled to the full range of services and supplies covered by the Medicare part B program when Part A does not pay for the nursing facility services themselves. This care is usually billed directly to Medicare by the providers who serve these patients. In 1995, Medicare paid an estimated $5.5 billion for services and supplies furnished to patients in nursing facilities.[19]

According to a January 1996 GAO report entitled *Providers Target Medicare Patients in Nursing Facilities*, fraudulent and abusive billing practices such as billing Medicare for unnecessary or undelivered services or misrepresenting service to obtain reimbursement "are frequent and widespread". This is so because:

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[19] HCFA contracts with insurers such as Blue Cross and Blue Shield plans, Aetna, and The Travelers Insurance Company, to process and pay claims submitted by providers. These contractors -- referred to as carriers under Medicare part B -- are responsible for the monitoring and analysis of claims both before and after payment to ensure that Medicare dollars are used to pay only reasonable and necessary claims.

> ...[s]everal features make Medicare beneficiaries in nursing homes an attractive target for fraudulent and abusive activity. *First*, because a nursing facility locates individual Medicare beneficiaries under one roof, unscrupulous billers of services can operate their schemes in volume. *Second*, in some instances, nursing facilities make patient records available to outside providers who are not responsible for the direct care of the patient, contrary to federal regulations which prohibit such inappropriate access. In such cases, nursing facilities -- however inadvertently -- enable exploitative providers to obtain the information on Medicare beneficiaries that they need to bill Medicare. *Third*, under HCFA's provisions for reimbursement, providers can bill Medicare directly, without the nursing facility or attending physician affirming whether the items were necessary or provided as claimed. Nor is the scrutiny at the claims processor level adequate . . . *Finally*, even when Medicare detects abusive billings and seeks recovery of unwarranted payments, it often receives little repayment from the wrongdoers who either go out of business or deplete their resources so that they lack the resources to repay the funds.

The rub of the problem is that under Medicare, neither the nursing facility nor the physician ensure that services and supplies outside providers claim to have furnished to beneficiaries in nursing facilities are in fact necessary and actually provided. Indeed, "independent providers and suppliers can bill Medicare directly for services or supplies without the knowledge of the beneficiary or the facility and companies that provide therapy are able to inflate their billings." (GAO Report, *Nursing Homes: Too Early to Assess New Efforts to Control Fraud and Abuse*, Testimony of Leslie G. Aronovitz (dated April 16, 1997) at 3). And the GAO has concluded that HCFA's provisions for reimbursing providers of these part B services and supplies furnish little early warning of egregious over-utilization or rapid increases in billings -- the telltale signs of fraud and abuse.

Thus, services provided to Medicare beneficiaries in nursing facilities offer a target of opportunity for the fraudulent schemes and billing abuses of the dishonest provider. In its studies of the nursing home industry, the GAO has documented numerous instances of fraud and abuse, including Medicare paying a nursing facility $4.3 million for heart monitoring services that were not actually delivered; a supplier billing Medicare for ostomy, enteral and surgical dressing supplies that it had not delivered; forging the attending physicians' signatures on the certificates

of medical necessity using samples of signed orders found in patients' files. (This case involved about 4,000 claims totaling about $1.5 million).

A critical flaw in the current system is that although federal requirements call for nursing facilities to perform numerous tasks to monitor and meet patient care needs, *there are no similar requirements to monitor claims submitted directly to Medicare for services or supplies provided to nursing facility patients.* (Jan. 1996 GAO Report at 6). Nursing facilities generally do not have the in-house capability to provide all the services and supplies to meet the needs of the facilities' patients. Provider representatives typically enter nursing facilities and offer to handle the entire transaction -- from reviewing medical records to identifying those patients their products or services can help, to billing Medicare -- with no independent involvement by nursing facility staff. Indeed, GAO has noted that some facilities allow providers or their representatives to review patient medical records despite federal regulations that prohibit such unauthorized review.

Although carriers employ a number of effective automated controls to prevent or remedy some inappropriate payments, such as suspending claims for further review that do not meet certain conditions for payments, the GAO has found typically that outlandish charges go unquestioned. And many carriers reviewed by the GAO had not put any "triggers" in place that would halt payment when cumulative claims exceed reasonable thresholds.[20] Some examples:

- One physician improperly billed $350,000 over a two year period for comprehensive physical examinations of residents without ever seeing a single resident. The physician also falsified records to indicate that nonexistent services were rendered.

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[20] For instance, one supplier submitted claims to a Medicare carrier for surgical dressings furnished to nursing facility patients. In the fourth quarter of 1992, the carrier paid the supplier $211,900 for surgical dressing claims. For the same quarter a year later, the contractor paid this supplier more than $6 million without becoming suspicious despite a 2,800-percent increase in the amount paid. In another case, a carrier's payments for a supplier's body jackets claims averaged about $2,300 per quarter for five consecutive quarters, then jumped to $32,000, $95,000, $235,000 and $889,000 over the next four quarters, with no questions raised by the carrier.

- A psychotherapist working in nursing facilities manipulated Medicare billing codes to charge for three hours of therapy for each resident when, in fact, he spent only a few minutes with each resident.

- A company providing mobile x-ray services repeatedly made visits to nursing facilities and billed the Medicare for two x-rays when in fact only one film was taken.

- In California, a former nursing home owner was ordered to pay more than $10.5 million for submitting over 7,000 false claims relating to a multimillion dollar Medicare fraud scheme. He billed Medicare for nonexistent medical supplies for his nursing homes and filed cost reports with false expenses. He attempted to conceal the scheme by supporting the cost reports with falsified medical records and fabricated invoices. He was sentenced earlier on the criminal aspect of the case to 11 years and 3 months imprisonment and ordered to pay $3.5 million in restitution. The amount of damages ordered to settle civil liabilities was treble the amount of restitution ordered. Medicare payments to the nursing homes were suspended.

- As a result of a joint investigation by the IG and FBI, a DME corporation agreed to a $3.6 million settlement. The corporation, a shell company with a Pennsylvania address, was established by a New York DME supplier solely to bill Pennsylvania's Medicare carrier for prosthetic and orthotic supplies provided to nursing home beneficiaries in New York. As a result of this billing arrangement, the corporation was overpaid $1.1 million over a 3-year period. As part of the agreement, the supplier will implement a corporate compliance plan.

The GAO has proposed at least two options to rectify fraud and abuse in nursing homes, both of which would require changing the way Medicare reimburses Part B services and supplies provided to nursing facility patients:

Unified billing by the nursing facility: under this approach, the nursing facility would bill Medicare for *all* services it has authorized to furnish to patients, whether payment is sought from Part A or B. This would be the case whether the facility provided the care itself or contracted for the services or supplies to be provided by someone else. Outside providers would be prohibited from billing Medicare directly and would, in effect, have to have agreements with nursing homes. By contrast, under the current system, outside providers can bill Medicare directly, without scrutiny by anyone where the care is delivered. Unified billing by the nursing facility would make it easier for Medicare to identify all the

services furnished to residents, which in turn would make it easier to control payments for those services.

Capping Payments: An alternative to paying on a fee-for-service basis as Medicare now does is to pay a fixed amount per beneficiary. This approach mirrors the payment method Medicare uses to reimburse most HMOs. As with HMOs, Medicare would pay the nursing facility a fixed amount per month for all Part B services and supplies provided to each resident beneficiary. [This is known as capitation, whereby Medicare pays HMOs a fixed amount per month for each beneficiary and this places the HMO at risk for health costs, giving them a financial incentive to control the use of services and avoid unnecessary care. HMOs may use their own staff of physicians and other providers to deliver care or may contract with individual providers or medical groups to deliver services.][21]

In its September 1996 Report, the HHS-IG concluded that the Part B program in nursing homes is particularly vulnerable to fraud, waste and abuse because payment rules and safeguards largely ignore the "special character" of the nursing home environment and the varied services and supplies which can be provided. Program vulnerabilities identified include the potential for duplicate payments by Medicare and Medicaid, lack of oversight by Medicare contractors, and questionable supplier or physician practices already documented in earlier studies. Significantly, based on its review, OIG determined that no effective mechanism currently exists to ensure the appropriate payment of DME and other ancillary services under Medicare Part B for beneficiaries in nursing homes.

According to its 1997 *Work Plan*, as part of *Operation Restore Trust*, the IG will identify and audit physicians with excessive visits to Medicare patients in skilled nursing facilities (SNF). Using computer screening techniques, the IG identified physicians in California with aberrant billing patterns for visits to SNF patients, such as an excessive number of visits in a given day

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[21] The GAO's short-term recommendations to the Secretary of HHS are (1) to establish, for procedure billing codes by provider or beneficiary, *thresholds for unreasonable cumulative levels or rates of increase* in services and charges, and to require Medicare carriers to implement automated screens that would *suspend* for further review claims exceeding those thresholds; and (2) to undertake demonstration projects designed to assess the relative costs and benefits of alternative ways to reimburse nursing facilities for part B services and supplies; these alternatives should include such options as unified billing by the nursing facility and some form of capped payment.

and excessive visits to the same beneficiaries. Individual reviews will be conducted for those physicians with the most egregious billing patterns.

E. *"Unbundling" Billing Practices: The "72 hour" Rule*: In 1995, the IG and the DOJ launched a national project to recover overpayments made to hospitals as a result of claims submitted for nonphysician outpatient services that were *already included* in the hospital's inpatient payment under the prospective payment system (PPS). Hospitals that submit claims for the outpatient service in addition to the inpatient admission are, in effect, submitting *duplicate claims* for the outpatient services. A prevalent pattern of abuse was identified through repeated IG audits of hospital for inpatient services under PPS. Prior to the inception of this project, the IG had issued four reports to HCFA identifying about $115.1 million in Medicare overpayments to hospitals caused by these improper billings. Essentially, the relevant statutory prohibitions forbid unbundling any service *administered on or within three days of* the date of admission regardless of whether the services related to the admission. *See Generally* 59 Fed. Reg. (January 12, 1994) at 1655.

This national project identified 4,660 hospitals that submitted improper billings for outpatient services. These hospitals will receive notification from the U.S. Attorney's Office concerning the IG's identification of erroneous claims and the facility's potential exposure under the Federal Civil False Claims Act. The hospitals will then be given the opportunity to enter into a settlement with the Government under which the financial exposure of the institution is substantially less than if pursued under the Act. Compliance measures to prevent and detect erroneous billing also are required under the terms of the settlement. As of September 1996, settlements have been executed with over 925 hospitals resulting in over $25 million in recoveries. Many of those hospitals argue that HHS has been arbitrary and capricious in its enforcement of this regulation and that the regulation is vague and ambiguous at best. The HHS-

IG states that the total anticipated recovery under this nationwide project is approximately $90-$110 million over the next 2 years from an estimated 4,446 hospitals.[22]

F. *The Oxygen Industry*: In FY 1996, Medicare's monthly rate per home oxygen patient was about $320. During the same period, the Veterans Administration ("VA") paid about $155 per month per patient. On the basis of certain cost differentials between the two systems, the GAO concludes that the VA payment rate was about $200 per month or $120 less than Medicare, after the necessary cost adjustments between the two systems.

Medicare's eligibility criteria for the home oxygen benefit are quite specific. Patients must have an appropriate diagnosis, such as chronic obstructive pulmonary disease and clinical tests of arterial blood gasses and oxygen saturation levels that document the need for supplemental oxygen. Medicare pays a fixed monthly fee to cover all of a patient's primary needs, regardless of the type of oxygen system supplied. The VA program and the Medicare program have the same eligibility criteria; *but where the VA competitively procures oxygen supplies and services, Medicare, like a fee-for-service insurer, simply reimburses suppliers for services provided to beneficiaries.*[23] Medicare does not directly contract for services with specific suppliers; therefore it cannot guarantee a fixed number of patients to any supplier. Rather, the Medicare providers themselves contract with oxygen suppliers and they were unwilling to disclose to the GAO what they were paying for oxygen. Hence the basic irrationality of the Medicare oxygen program: whereas oxygen price under VA system is essentially a volume (and thus cost) based method of deriving a fair market price, the Medicare program reimburses providers on a

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[22] As the IG points out, one of the most important parts of this project is the stipulation in each settlement agreement that each hospital will assure compliance with proper billing for inpatient/outpatient services.

[23] Medicare payments for DME are based on a schedule methodology established by Congress in the 1984 Omnibus Budget Reconciliation Act. This statutory prescribed payment methodology does *not* consider changes in technology or any other factors impacting suppliers costs. In fact, the GAO has reported that if Medicare had paid the VA's rate for oxygen, Medicare could have saved $500 million in FY 1996.

handsome fee-for-service basis, *regardless of the actual cost the provider has incurred.*[24] As the GAO notes, the VA's competitive contracting process is attractive because it allows for economies of scale and, unlike the fee-for-service system, creates few incentives for abusive over-prescription and utilization. On the flip side, however, competitive bidding could adversely impact small businesses in less densely populated states. One solution to this concern, however, could be predicating any reforms on the basis of *actual costs*, thus entities in regions where actual costs are higher than average will receive a higher reimbursement rate.

G. *Billing Abuses In The Training of Residents*: Under current law, Medicare pays teaching hospitals for its share of the costs of providing graduate medical education. *Direct* graduate medical education payments (direct GME) are based on a hospital's *per resident* costs (*i.e.*, resident and faculty salaries and fringe benefits, and overhead costs related to teaching activities) and the number of full-time-equivalent residents the hospital employs. *Indirect* costs are reimbursed through the indirect medical education (IME) payment adjustment. This adjustment is designed to compensate teaching hospitals for their relatively higher costs attributable to the involvement of residents in patient care and the severity of illness of patients requiring specialized services available only in teaching hospitals. The IME adjustment to Medicare's hospital payments is currently increased approximately 7.7% for each 10% increase in a hospital's ratio of interns and residents to beds.

A nationwide initiative to review compliance with rules governing *physicians at teaching hospitals* ("PATH") and other Medicare payment rules grew out of extensive work performed by the IG at the University of Pennsylvania Hospital. That review focused on compliance with the Medicare rule that essentially prohibits staff physician billing in addition to resident billing unless the staff physician actively participated in the treatment (the "elbow-to-elbow" rule). The IG

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[24] As part of its study in comparing what the Medicare program pays for oxygen with what the VA program pays, the GAO discounted from the Medicare program the fact that, unlike its VA counterparts, Medicare suppliers bear the administrative costs of processing certificate of medical necessity (which are not required under the VA system, which itself pre-approves each patient for home oxygen services) and billing patients for a 20 percent copayment.

found that not only was the institution not complying with this rule but that teaching physicians also were improperly up- coding the level of service provided in order to maximize Medicare reimbursement. This review resulted in the Government's recovery of more than $30 million, including damages under the Federal Civil False claims Act. As part of the negotiated settlement, the responsible parties also avoided program exclusion under IG authorities. In addition, also last year, Thomas Jefferson University Hospital agreed to pay $12 million after an audit turned up false claims. (In a separate investigation, in April 1997 New York University Medical center agreed to pay $15.5 million to settle allegations that it filed false claims in connection with federal research grants.)

The IG initiated the PATH project to determine whether and to what extent similar problems exist at other teaching hospitals. The nationwide PATH reviews focus on compliance with the Medicare rule and the appropriateness of service codes.[25]

H. *Marketing Abuses in the HMO Industry*: The GAO reports huge variations in complaint levels *and* disenrollment rates for Medicare-risk HMOs, and recommends that HCFA publish comprehensive comparative data to help people decide which HMO to join. The study of HMOs in Miami and Los Angeles found a more than tenfold difference in annual disenrollment rates: Kaiser Permanente in Los Angeles with a 4 percent rate retained the most members while Foundation Health Plan topped the chart with a huge 42 percent disenrollment. Disenrollment rates are significant from a consumer protection standpoint because Medicare-risk enrollment continues to swell, as it has by 80 percent over the last two years. One GAO probe

[25] Active participation includes arrangement, at the hospital's or practice group's expense, for an independent review conducted by a third party, using IG's review protocol. A hospital must be an institution that receives graduate medical education payments under Medicare Part A and a group must be affiliated with such an institution. To receive the benefits of active participation in a PATH review, they must adhere to principles set out in the review protocol.

(a seven month investigation of Miami and Los Angeles HMOs) study found a 42 percent disenrollment rate at Los Angeles' Foundation Health.[26]

HMOs enter into risk contracts with HCFA to provide Medicare-covered services to beneficiaries who enroll. Risk plans assume all the financial risk associated with providing Medicare-covered services to enrolled beneficiaries in return for a monthly per capita premium -- the adjusted average per capita cost (AAPCC) payment -- from HCFA for each Medicare beneficiary enrolled. The amount of these AAPCC-based payments varies by county. HCFA pays some HMOs on a cost-reimbursement basis, with these HMOs assuming no risk that fees will be insufficient to cover cost.

Before an HMO can enter into a risk contract, the law requires that have at least 5,000 commercial enrollees. An HMO serving primarily rural areas must have at least 1,500 members. In addition, the Medicare law's "50-50 rule" states that no more than 50 percent of an HMO's enrollment may be Medicare beneficiaries and Medicaid recipients.

Medicare beneficiaries enrolled in a risk HMO face a "lock-in" requirement. Once they enroll, they must receive virtually all their health care services through the HMO. If a beneficiary goes outside the HMO for any health care services, neither the HMO nor Medicare is required to pay the cost. Exceptions are made for emergency and similar type of care, which can be obtained anywhere in the country and for which the HMO should pay. A few risk HMOs now offer a "point of service" option through which beneficiaries can receive certain services outside the plan's network of providers but must pay more than for "within-plan" services.

Medicare beneficiaries enrolled in HMOs can "vote with their feet" at any time and for any reason (disenrollment is generally effective the first day of the month following the receipt

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[26] According to HCFA's recently published regulations on physician incentive plans in managed care settings, HMOs with providers that have been determined to be at substantial financial risk will be required to conduct a survey of current and recently disenrolled members. Plans that are not required to do a survey under the physician incentive regulations are not required to conduct a disenrollment survey. *See Medicare Managed Care: HCFA Missing Opportunities to Provide Consumer Information* (April 10, 1997) at 9 n.10.

of the beneficiary's disenrollment request) and either switch plans or go back to fee-for-service Medicare. Thus, GAO recommends using a comparison of HMO disenrollment rates as an indicator of beneficiaries' relative satisfaction with plans' service, benefits, out-of-pocket costs, and quality. Although HCFA collects this information, they *do not systematically compare HMO disenrollment rates*. HCFA contends that disenrollment statistics do not distinguish among the many reasons for voluntary disenrollment and therefore are not a good indicator of a plan's quality. However, GAO contends that they can serve as a caution signal -- particularly if the plan has a disenrollment rate that is substantially higher than its competitors.

The HHS Inspector General widely disseminates information on excluded providers through monthly reports and periodic cumulative listings to various state and federal agencies so that they, too, will remove these providers from their programs. However, one GAO study concludes that HHS often has difficulty excluding providers who appear on the lists. *First*, the states have difficulty identifying individuals -- such as nurses, pharmacists, or physicians -- who are employed by hospitals, nursing homes, pharmacies, and HMOs but that bill the program under the entity's billing number. These providers, once sanctioned, can change employers or move to other states and potentially continue to provide services through federal health care programs without detection. *Second*, providers sometimes are not identified because states tend to use the IG's monthly list for a onetime check against their active provider files. Thus, they may not review prior monthly lists.

IV. Conclusion

As the next step, subcommittee staff is planning on developing an investigative record focusing on the more problematic areas of the Medicare program, particularly the home health care and nursing home industries, the DME industry and hospital double billing. It is our aim to develop an illustrative record of fraud in abuse in these areas, thereby providing the groundwork for further hearings in the Fall.

GLOSSARY OF TERMS

HHS	Health and Human Services
HHS/IG	Health and Human Services, Inspector General
HCFA	Health Care Financing Administration
SNF	Skilled Nursing Facility (covered under Part A only; for 100 days following a hospital admission)
DME	Durable Medical Equipment (wheel chairs, beds, crutches, etc.)
NSC	National Supplier Clearinghouse (monitors supplier enrollments)
PPS	Prospective Payment System
GME	Graduate Medical Education
PATH	Physicians at Teaching Hospitals (Medicare pays teaching hospitals for its share of the costs of providing graduate medical education)
CHAMPUS	Civilian Health and Medical Program of the Uniformed Services (the military's health care system)
Elbow-to-Elbow	Physicians can only bill for residents when physicians actively participate in the treatment.
Medicare Part A	Provides premium-free coverage of costs involved with hospitalization and certain follow-up services for individuals 65 years and over as well as certain disabled persons.
Medicare Part B	Provides supplementary coverage of costs involved with physician services and related supplies financed through a combination of beneficiary premiums (25%) and general revenues.
Intermediaries	Contractors that handle Part A claims (hospitals, skilled nursing facilities, and home health agencies).
Carriers	Contractors that handle Part B claims (physicians, laboratories, and equipment suppliers).
Up-Coding	Practice of claiming an item or service based on a code which results in greater payment than appropriate.
Unbundling	Duplicate claims.
72-Hour Rule	Hospitals are prohibited from billing any service administered during or within three days of the date of admission.

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June Gibbs Brown
Inspector General
Department of Health and Human Services

Good morning, Mr. Chairman. I am June Gibbs Brown, Inspector General of the Department of Health and Human Services (HHS), and I am pleased to report to you on our audit of the Health Care Financing Administration's (HCFA) Fiscal Year (FY) 1996 financial statements. With me this morning is Joseph E. Vengrin, Assistant Inspector General for Audit Operations and Financial Statement Activities.

My testimony today will focus on our extensive review of the correctness of Medicare payments and the reliability of HCFA's financial reports. Further details are provided in our report which is being released at this hearing.

Before beginning my testimony, I want to acknowledge the cooperation and support we received during this audit from the Department and HCFA. A review of this magnitude and complexity could not have been carried out without HCFA's excellent cooperation and assistance in making available medical review staff at the Medicare contractors and the peer review organizations (PRO). We look forward to working with them again on the FY 1997 audit. Also, I would like to point out that this audit was performed in close cooperation with the General Accounting Office (GAO) due to HCFA's significance in the consolidated financial statements of the Federal Government, which GAO has the responsibility to audit. The GAO participated extensively in various segments of the audit and provided significant contributions.

We undertook this audit as part of our implementation of the Government Management Reform Act of 1994 which requires audited financial statements. As you know, the intended purpose of financial statements is to provide a complete picture of agencies' financial operations, including what they own (assets), what they owe (liabilities), and how they spend taxpayer dollars. The purpose of our audit was to independently evaluate the reliability of such statements. While we issued audit reports on portions of HCFA's financial statements in previous FYs, this year marks our first comprehensive financial statement audit of HCFA.

Medicare Claims Testing

The HCFA is the largest single purchaser of health care in the world. With expenditures of approximately $300 billion, assets of $175 billion, and liabilities of $50 billion, HCFA is also the largest component of HHS. Medicare and Medicaid outlays represented 33.2 cents of every dollar of health care spent in the United States in 1996.

In view of Medicare's 38 million beneficiaries, 800 million claims processed and paid annually, complex reimbursement rules, decentralized operations, and health care consumers who may not be alert to improper charges, the Medicare program is inherently at high risk for payment errors. Medicare, like other insurers, makes payments based on a standard claims form. Providers typically bill Medicare using standard procedure codes without submitting detailed supporting medical records. However, Medicare regulations specifically require providers to retain supporting

documentation and to make it available upon request. Because of the high risk in health insurance reimbursement and its dollar magnitude in relation to financial statement impact, i.e., $168.6 billion in Medicare fee-for-service claims, we embarked on a comprehensive review of claims expenditures and supporting medical records.

Our primary objective was to determine whether Medicare benefit payments were made in accordance with Title XVIII of the Social Security Act (Medicare) and implementing regulations. Specifically, we examined whether services were: (1) furnished by certified Medicare providers to eligible beneficiaries; (2) reimbursed by Medicare contractors in accordance with prescribed Medicare laws and regulations; and (3) medically necessary, accurately coded, and sufficiently documented in the beneficiaries' medical records.

This is the first time in the history of the Medicare program that a comprehensive, statistically valid sample of Medicare fee-for-service claims has ever been taken to determine the correctness of payments. The results of our claim testing corroborate past program findings that the Medicare program is inherently vulnerable to improper provider billing practices.

We estimate that during FY 1996 net overpayments totaled about $23.2 billion nationwide, or about 14 percent of total Medicare fee-for-service benefit payments. These improper payments could range from inadvertent mistakes to outright fraud and abuse. We cannot quantify what portion of the error rate is attributable to fraud. Specifically, 99 percent of the improper payments were detected through medical record reviews coordinated by the Office of Inspector General (OIG) in conjunction with medical personnel. When these claims had been submitted for payment to Medicare contractors, they contained no visible errors.

Review Methodology

To accomplish our objective, we used a multistage, stratified sample design. The first stage consisted of a random selection of 12 contractor quarters during FY 1996, and the second stage consisted of a random sample of 50 beneficiaries from each contractor quarter. The resulting sample of 600 beneficiaries produced 5,314 claims for review. The population from which the sample was drawn represented $168.6 billion in fee-for-service payments.

We reviewed all claims processed for payment for each selected beneficiary during the 3-month period. Specifically, we used medical review personnel from HCFA's Medicare contractors (fiscal intermediaries and carriers) and PROs who regularly assess medical records to determine whether services billed were reasonable, medically necessary, adequately documented, and coded correctly in accordance with Medicare reimbursement rules and regulations. We asked the Medicare contractors to send a letter to each provider in our sample to obtain copies of all medical records supporting services billed. In the event that a response was not received, a second letter was sent, and in most instances additional telephone calls were made. Throughout the medical review, we coordinated OIG and medical review efforts to ensure consistency and accuracy.

Concurrent with the medical review, we made additional detailed claims reviews, focusing on past incorrect billing practices, to determine whether: (1) the contractor paid, recorded, and reported the claim correctly; (2) the beneficiary and the provider met all Medicare eligibility requirements; (3) the

contractor did not make duplicate payments or payments for which another primary insurer should have been responsible (Medicare secondary payer); and (4) all services were subjected to applicable deductible and co-insurance amounts and were priced in accordance with Medicare payment regulations.

Projecting the 1,577 claims not meeting Medicare laws and regulations to the total FY 1996 fee-for-service Medicare benefit payments, we estimated that the range of improper payments at the 95 percent confidence level is $17.8 billion to $28.6 billion, or 11 percent to 17 percent. Therefore, we used the midpoint of this range, or $23.2 billion (about 14 percent of the $168.6 billion in processed fee-for-service payments) as the projected estimate of improper payments. However, the precision of the dollar estimate by specific type of claim and type of error is not sufficient to use for benchmarking purposes. This information is being provided to HCFA in order that appropriate corrective action can be taken. Also, this estimate of improper payments does not take into consideration waste (excessive pricing) and numerous kinds of outright fraud, such as phony records or kickbacks.

Types of Errors Found

As shown in the following chart, most of the errors we found fell into four general categories: (1) documentation, which includes both insufficient and no documentation; (2) lack of medical necessity; (3) incorrect coding; and (4) noncovered/unallowable services.

Estimated Amount of Improper Payments (By Type of Error)

Type of Improper Payment	Estimated Dollars In Improper Payments *(in millions)*	Improper Payments as a Percent of Total
Documentation:	**$10,846**	**46.76%**
Insufficient Documentation	*7,596*	*32.75%*
No Documentation	*3,250*	*14.01%*
Lack of Medical Necessity	**8,529**	**36.78%**
Incorrect Coding	**1,978**	**8.53%**
Noncovered or Unallowable Services	**1,219**	**5.26%**
Other	**620**	**2.67%**
Total	**$23,192**	**100.00%**

Lack of Documentation. The most pervasive error type in our sample is insufficient or no documentation, which accounts for $10.8 billion, or approximately 47 percent, of the $23.2 billion in improper payments. This can be further broken down between insufficient documentation totaling $7.596 billion (33 percent) and no documentation totaling $3.250 billion (14 percent). As previously indicated, if providers failed to submit documentation or submitted insufficient documentation, the contractors generally requested supporting medical records at least three times before determining

the payment to be improper. Medicare regulation, 42 CFR 482.24(c), specifically requires providers to maintain medical records that contain sufficient documentation to justify diagnoses, admissions, treatments performed, and continued care.

Some examples of documentation problems follow:

- **Skilled Nursing Facility (SNF).** A hospital-based SNF was paid $9,365 for a 25-day skilled nursing stay even though the medical records did not support the need for skilled care.

- **Physician.** A physician who was paid $523 for 10 hospital visits could support only 2 visits, resulting in a $386 overpayment.

- **Clinical Laboratory Services.** One clinical laboratory billed Medicare $64 but could not provide the doctor's order authorizing the service.

Lack of Medical Necessity. A lack of medical necessity is the second highest error category, accounting for $8.5 billion, or 37 percent, of the $23.2 billion in improper payments. Medical reviewers followed their normal claims review procedures to determine whether the medical records supported the Medicare claims. Their findings showed that in these cases, based upon the "look behind" review of the medical records employed in our audit, the services as billed were not medically necessary.

Some examples include:

- **SNF.** A SNF was paid $15,362 for 61 days of care even though the medical records clearly documented that the individual did not need this level of care.

- **Home Health Agency (HHA).** An HHA was paid $11,790 for skilled physical therapy, skilled nursing care, and home health aide services when the medical records clearly indicated that the patient had no functional diagnosis requiring physical therapy or skilled nursing care.

  Another HHA received payment of $1,528 for home health services which were not medically necessary because the services entailed custodial care (care to assist patients with daily living or meeting personal needs) rather than skilled nursing care. Therefore, the medical reviewer disallowed the entire claim.

Incorrect Coding. Incorrect coding is the third highest category, accounting for an estimated $2 billion, or about 8.5 percent, of the $23.2 billion in improper payments. The medical industry uses a standard coding system to bill Medicare for services provided. For most of the coding errors, the medical reviewer determined that the documentation submitted by the provider supports a lesser reimbursement code. However, we did find a few instances of downcoding which were offset against identified upcoding situations.

Examples of incorrect coding follow:

- **Inpatient Hospital.** One beneficiary had three separate hospital inpatient admissions during a 3-month period. Medicare paid $8,533 for each admission under one diagnosis-related group (DRG). Based on the medical records, the medical reviewer concluded that all three claims should have been paid under a less extensive and less costly DRG that paid $6,290, resulting in a total overpayment of $6,729.

- **Physician.** A physician billed Medicare for a hospital emergency room visit for "treatment of a medical problem of high severity that requires urgent evaluation by the emergency room physician" when the medical records support only treatment for problems of moderate severity.

  Another physician billed Medicare for subsequent hospital care requiring "a medical decision of high complexity by the provider" when it should have been for medical care "that is straightforward or of low complexity."

Noncovered/Unallowable Services. Unallowable services account for an estimated $1.2 billion, or about 5 percent, of the $23.2 billion in improper payments. Medicare unallowable services are defined as those that Medicare will not reimburse because the services do not meet Medicare reimbursement rules and regulations.

Following are some examples of noncovered or unallowable services identified during our review:

- **Physician Claims.** A physician billed Medicare for an electrocardiogram and various laboratory tests. After reviewing the provider's medical records, the medical reviewer concluded the billed services should be denied because the services were performed as part of the beneficiary's routine yearly physical examination, which is not a Medicare-covered service.

- **Hospital Outpatient.** A patient was evaluated for foot orthotics, and impressions were taken to make soft arch supports. Arch supports are not covered by Medicare. Although the patient signed a hospital form acknowledging that arch supports were not covered by Medicare, the claim was billed as though it were a Medicare-covered service.

- **SNF Services.** Most of the errors occurred when the SNF billed Medicare separately for various routine services already included in its flat-rate reimbursement.

A further analysis of the errors, as illustrated in the chart herein, shows that 88 percent of the $23.2 billion in improper payments occurred within 6 provider types: (1) inpatient prospective payment system (PPS), (2) physician, (3) home health agency, (4) outpatient, (5) skilled nursing facility, and (6) laboratory.

Estimated Amount of Improper Payments
By Type of Error/Provider

	Types of Error (in millions)						
Type of Provider	*Insufficient/ No Documentation*	*Lack of Medical Necessity*	*Incorrect Coding*	*Noncovered/ Unallowable Service*	*Remaining Errors*	*Total*	*Percentage of Improper Payments*
Inpatient PPS	$1,040	$3,301	$900		($2)	$5,239	22.59%
Physician	2,756	614	1,070	$329	258	5,027	21.68%
Home Health Agency	1,684	1,935			31	3,650	15.74%
Outpatient	2,286	356	1	85	82	2,810	12.12%
Skilled Nursing Facility	1,056	1,365			3	2,424	10.45%
Laboratory	1,173	146	(14)	30	2	1,337	5.76%
Subtotal	$9,995	$7,717	$1,957	$444	$374	$20,487	88.34%
Other Providers	851	812	21	775	246	2,705	11.66%
Total	$10,846	$8,529	$1,978	$1,219	$620	$23,192	100.00%
Percentage of Improper Payments	46.76%	36.78%	8.53%	5.26%	2.67%	100%	

We believe that it would be prudent for HCFA to focus corrective action in these specific provider groups. We have provided HCFA a detailed list of certain procedure codes that have a high frequency of error.

Conclusions and Recommendations: Claims Testing

The HCFA uses numerous prepayment and postpayment safeguards to prevent or detect improper Medicare fee-for-service benefit payments. For instance, prepayment edits help ensure that billed services are paid accurately and timely, but they do not always detect the improper services that we identified, i.e., undocumented, medically unnecessary, or upcoded services. The HCFA's postpayment medical review is generally effective for identifying abuse and overutilization and for detecting payments for unsubstantiated, medically unnecessary, and noncovered services. However, funding limitations have significantly constrained medical review to the extent that currently only about 3 of every 1,000 providers are subjected to postpayment medical review audit.

Due to limited funding, resources devoted to prepayment and postpayment review have not kept pace with the increase in claims or questionable billing practices by providers. However, even the best developed prepayment and postpayment controls at the contractor level may not be sufficient to

prevent or detect material Medicare program losses resulting from excessive, unnecessary, or unsubstantiated provider services. Therefore, HCFA needs to consider stronger deterrents to reduce improper benefit payments and to protect the solvency of the Medicare trust funds.

As our results indicate, a significant opportunity exists for providers to: (1) bill for services that are excessive or not medically necessary; (2) bill for services that are unsubstantiated by the beneficiaries' medical records; and (3) improperly code services to obtain higher Medicare payment than the appropriate code would permit. Existing risks are sharply increased by the significant growth in Medicare claims and expenditures, the inherent complexities of the Medicare program, and restricted funding for program safeguards to deter abusive providers.

To ensure provider compliance with Medicare reimbursement rules and regulations, stronger oversight by HCFA is needed. Among the more important issues HCFA faces in the immediate future is preserving the solvency of the Medicare trust funds. As part of its strategic plan to safeguard these funds, we recommend that HCFA:

① Develop a system that objectively and periodically estimates improper payments and disclose the range of such overpayments in its financial statements.

② Develop a national error rate to focus corrective actions and measure performance in reducing improper payments.

③ Enhance prepayment and postpayment controls by updating computer systems to better detect improper Medicare claims.

④ Direct contractors to expand provider training to further emphasize the need to maintain medical records that contain sufficient documentation and the penalties for not doing so.

⑤ Direct contractors to make followup evaluations of specific procedure codes we identified with high error rates and consider whether identified providers should be placed on prepayment medical review.

⑥ Ensure that contractors adjust their Medicare accounts for improper payments we identified, initiate recovery from the identified providers, and follow up with the providers to correct deficiencies and to determine whether other systemic problems need to be corrected.

Disclaimer of Opinion on HCFA's Financial Statements

Lastly, I would like to focus my testimony on HCFA's financial reporting. We were unable to reach conclusions on several billion dollar accounts in HCFA's FY 1996 financial statements. This does not mean that these numbers are incorrect; rather, they are not supported by current accounting or audit data. The auditing term is a "disclaimer of opinion," which means that we were not able to determine if HCFA's financial statements were fairly presented because the documentation was not

adequate or available to support the reported financial statement amounts. Specifically, we were not able to gather sufficient evidence on the validity or reasonableness of the following:

- **Medicare Accounts Payable--services provided at year end but not yet paid.** As of September 30, 1996, reported Medicare accounts payable totaled $36.1 billion and comprised 71 percent of total liabilities. These payables represent HCFA's estimate of actual or potential claims for services provided to beneficiaries but not paid at the end of the FY. The HCFA did not provide adequate support for this estimate. Additionally, we were unable to determine, through alternative audit procedures, if the September 30, 1996, Medicare accounts payable balance was fairly presented. Specifically, we could not find support for $18.3 billion of the accounts payable amount using historical claims data adjusted for costs associated with interim payments to providers and settlements from providers' cost reports. Moreover, using expenditure trends to assess the reasonableness of the payables estimate, we noted that Medicare expenditures increased 16 percent while the accounts payable increased 64 percent. Historically, when compared with expenditures, the payables had erratic and inconsistent changes which HCFA could not explain.

- **Supplementary Medical Insurance (SMI) Revenue (Part B Medicare).** The Social Security Administration is responsible for withholding premiums from SMI beneficiaries' Social Security checks and for transferring these funds to the SMI trust fund each month. Because the SMI revenue has not been audited and because we lack statutory authority to do this work, we were unable to determine the validity and completeness of the SMI revenue account of $18.9 billion, as well as the Federal match of $61.7 billion.

- **Medicare Accounts Receivable--overpayments to providers owed to HCFA.** We could not determine the validity of the $2.68 billion Medicare accounts receivable balance because Medicare contractors did not maintain adequate documentation to support reported accounts receivable activity and to provide adequate audit trails. For example:

  - Some Medicare Part A providers are paid on an interim basis using prior claims activity and related costs (referred to as the periodic interim payment (PIP) method of reimbursement). Some contractors used inconsistent accounting procedures to calculate receivables and payables resulting from the PIP reimbursement process. One contractor, for instance, incorrectly included $700 million as a receivable when in fact all but $32 million was a payable. Also, four contractors did not record either PIP receivables or payables. One additional contractor included a $25 million PIP payable, rather than an $80 million PIP receivable.

  - At another contractor location, approximately $7 million could not be reconciled to reported amounts.

- **Cost Report Settlements--HCFA's process for determining final payments to certain institutional providers**. About 38,000 institutional providers are paid interim amounts throughout the year and subsequently file a cost report to reconcile actual costs to the interim payments received. The HCFA's cost report audit process is limited to specific issue areas or cost report line items and covers only a limited number of providers. Due to the limited scope of contractors' audits of provider cost reports, we were unable to determine what adjustments, if any, were necessary to the $3 billion in prior-year cost settlements reported in the FY 1996 financial statements.

Conclusion

I appreciate the opportunity to appear before you today and to share our report with you. As demonstrated in our review, unnecessary or improper benefit payments continue to plague the Medicare program. Existing risks are sharply increased by the significant growth in Medicare claims and expenditures, the inherent complexities of the Medicare program, and restricted funding for program safeguards to deter abusive providers. Our review has also demonstrated the need for stronger oversight by HCFA to ensure provider compliance with Medicare reimbursement rules and regulations and the necessity of subjecting claims to medical review. I am pleased to say that HCFA and the Department's Chief Financial Officer are aggressively working on a corrective action plan addressing our concerns.

Finally, I would like to note that we have already started our audit work on HCFA's FY 1997 financial statements. As in FY 1996, we will be performing comparable fee-for-service claims testing. I welcome your questions.

Estimated Amounts of Improper Payments

(By Type of Error)

TYPE OF IMPROPER PAYMENT	ESTIMATED DOLLARS IN IMPROPER PAYMENTS (in millions)	IMPROPER PAYMENTS AS A PERCENT OF TOTAL
Documentation:	**$10,846**	**46.76%**
Insufficient Documentation	$7,596	32.75%
No Documentation	3,250	14.01%
Lack of Medical Necessity	**8,529**	**36.78%**
Incorrect Coding	**1,978**	**8.53%**
Non-covered or Unallowable Services	**1,219**	**5.26%**
Other	**620**	**2.67%**
TOTAL	**$23,192**	**100.00%**

Estimated Amounts of Improper Payments

(By Type of Error/Provider)

TYPE OF PROVIDER	TYPES OF ERROR (in millions)						
	Insufficient/No Documentation	Lack of Medical Necessity	Incorrect Coding	Noncovered/ Unallowable Service	Remaining Errors	TOTAL	Percentage of Improper Payments
Inpatient PPS	$1,040	$3,301	$900		($2)	$5,239	22.59%
Physician	2,756	614	1,070	$329	258	5,027	21.68%
Home Health Agency	1,684	1,935			31	3,650	15.74%
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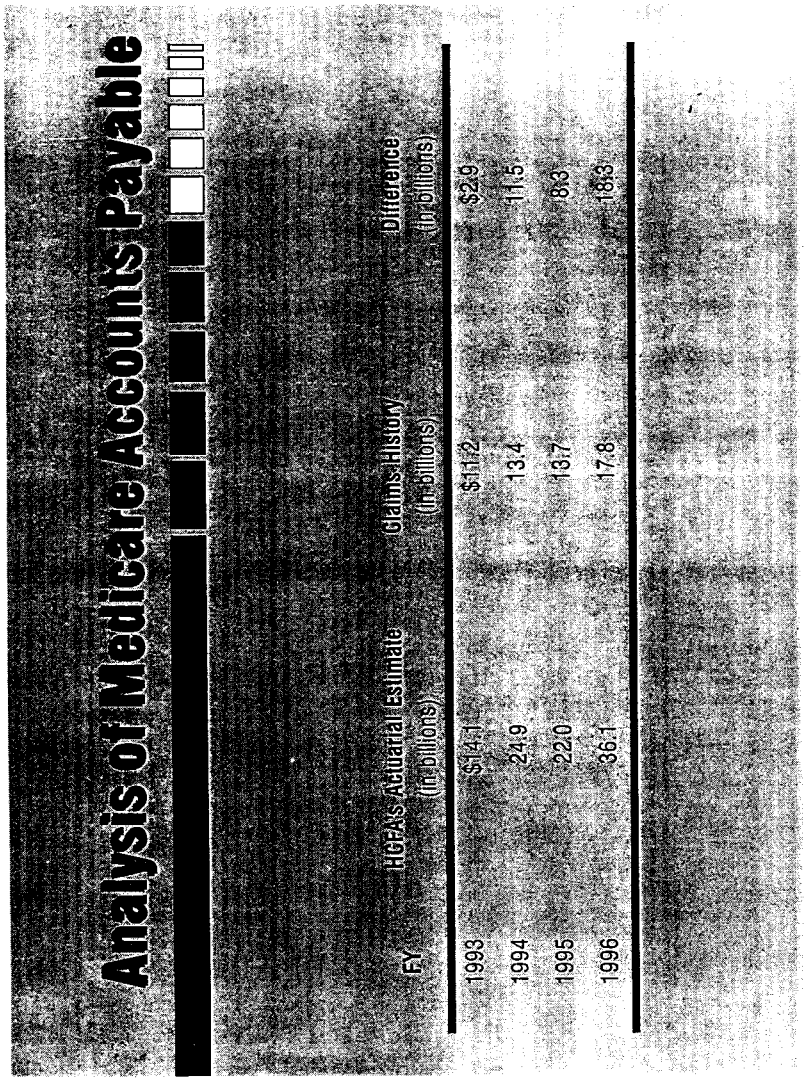
Skilled Nursing Facility	1,056	1,365			3	2,424	10.45%
Laboratory	1,173	146	(14)	30	2	1,337	5.76%
SUBTOTAL	$9,995	$7,717	$1,957	$444	$374	$20,487	88.34%
Other Providers	851	812	21	775	246	2,705	11.66%
TOTAL	$10,846	$8,529	$1,978	$1,219	$620	$23,192	100.00%
Percentage of Improper Payments	46.76%	36.78%	8.53%	5.26%	2.67%	100.00%	


Analysis of Medicare Accounts Payable
FY
HCFA's Actuarial Estimate (in billions)
Claims History (in billions)
Difference (in billions)
1993
$14.1
$11.2
$2.9
1994
24.9
13.4
11.5
1995
22.0
13.7
8.3
1996
36.1
17.8
18.3

Concerns Resulting in Disclaimer

NAME OF ACCOUNT	PROBLEM
Medicare Accounts Payable ($36.1 Billion): estimated amount medicare owes providers	• Questionable claims support • Actual claims data could not support $18.3 billion of the payables estimate
SMI Revenue – Medicare Part B Program ($18.9 Billion, $61.7 Billion Federal Match): amount of premiums collected from beneficiaries and matched by contributions from the Federal Government	• No audit work performed outside of HHS/OIG • HHS/OIG lacks authority to audit other Federal agencies
Medicare Accounts Receivable ($2.68 Billion): amount of overpayments due from providers	• Incomplete accounting records • Millions could not be reconciled to reported amounts • Reporting procedures not being followed, resulting in unreliable financial information
Cost Report Settlements ($3.0 Billion): amounts paid during the year for settlement of cost reports	• No process in place to complete an audit • 37,700 cost reports filed annually • Unable to determine if amounts paid for final cost settlements meet medicare guidelines

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REPORT ON THE FINANCIAL STATEMENT AUDIT OF THE HEALTH CARE FINANCING ADMINISTRATION FOR FISCAL YEAR 1996

Release of Report Embargoed Until
Thursday, July 17, 1997

JUNE GIBBS BROWN
Inspector General

A-17-95-00096
JULY 1997

DEPARTMENT OF HEALTH & HUMAN SERVICES — Office of Inspector General

Memorandum

Date JUL 17 1997

From June Gibbs Brown
Inspector General

Subject Report on the Financial Statement Audit of the Health Care Financing Administration for Fiscal Year 1996 (CIN: A-17-95-00096)

To Bruce C. Vladeck
Administrator
Health Care Financing Administration

Attached is our final report entitled *Report on the Financial Statement Audit of the Health Care Financing Administration for Fiscal Year 1996.*

Because of the significance of the following matters and because we were not able to apply other auditing procedures to satisfy ourselves as to the fair presentation of the accounts involved, the scope of our work was not sufficient to enable us to express, and we do not express, an opinion on the Health Care Financing Administration's (HCFA) Fiscal Year (FY) 1996 financial statements.

- **Medicare Accounts Payable.** The HCFA did not provide adequate support for its accounts payable estimate. We were unable to determine through alternate audit procedures whether the $36.1 billion reported Medicare accounts payable balance was fairly presented.

- **Supplementary Medical Insurance (SMI) Revenue.** The Social Security Administration is responsible for withholding premiums from SMI beneficiaries' Social Security checks and for transferring these funds to the SMI trust fund each month. Because the SMI revenue has not been audited and because the Office of Inspector General lacks legislative authority to perform this work, we were unable to determine whether the SMI revenue account of $18.9 billion, as well as the Federal match of $61.7 billion, which is material to HCFA's statement of operations, was fairly presented.

- **Medicare/Medicaid Accounts Receivable.** Medicare contractors did not maintain adequate documentation to support reported accounts receivable activity. As a result, we could not determine if the reported $2.68 billion Medicare accounts receivable balance was fairly presented. In addition, we were unable to perform sufficient procedures to satisfy ourselves as to the reasonableness of Medicaid accounts receivable.

- **Cost Report Settlements.** Due to the limited scope of contractors' audits of provider cost reports, we were unable to determine what adjustments, if any, were necessary to the $3 billion in cost settlements from prior years reported in the FY 1996 financial statements.

As discussed in our report on compliance with laws and regulations, we estimate that during FY 1996 net overpayments totaled about $23.2 billion, or about 14 percent of the $168.6 billion in processed Medicare fee-for-service payments reported by HCFA. Because the Medicare program does not currently provide reasonable assurance of detecting and preventing improper Medicare payments, this also constitutes a material internal control weakness, as discussed below. We are recommending that HCFA develop a process for estimating a national payment error rate as part of its corrective actions on this issue.

Our report on internal controls notes four internal control weaknesses that we consider to be material under standards established by the American Institute of Certified Public Accountants and Office of Management and Budget Bulletin 93-06:

① The HCFA does not have a process for estimating a national error rate for improper payments.

② The HCFA does not have an acceptable method for estimating Medicare accounts payable for financial statement reporting purposes.

③ The HCFA does not have an integrated financial reporting system to properly account for Medicare accounts receivable and other financial management and reporting issues.

④ The HCFA central office has deficiencies in electronic data processing controls relating to security access, system application development, and service continuity.

The material weaknesses relating to Medicare accounts payable and Medicare accounts receivable were reported in previous Chief Financial Officers Act audit reports and remain uncorrected.

We have incorporated informal comments to the draft report where appropriate. Officials in your office have concurred with our recommendations and are in the process of taking corrective action. We appreciate the cooperation the HCFA staff has given us in this audit.

We would appreciate your views and information on the status of any further action taken or contemplated on our recommendations within the next 60 days. If you have any questions, please contact me or have your staff contact Joseph E. Vengrin, Assistant Inspector General for Audit Operations and Financial Statement Activities at (202) 619-1157.

To facilitate identification, please refer to Common Identification Number A-17-95-00096 in all correspondence relating to this report.

Attachment

cc:
Steven A. Pelovitz
Chief of Operations
Health Care Financing Administration

Michelle Snyder
Deputy Chief of Operations
Health Care Financing Administration

Elizabeth Cusick
Director, Office of Financial Management
(and Chief Financial Officer)
Health Care Financing Administration

INDEPENDENT AUDITOR'S REPORT
INSPECTOR GENERAL'S REPORT ON THE HEALTH CARE FINANCING ADMINISTRATION'S FINANCIAL STATEMENTS FOR FISCAL YEAR 1996

To: Bruce C. Vladeck
Administrator
Health Care Financing Administration

We undertook to audit the accompanying combined statement of financial position of the Health Care Financing Administration (HCFA) as of September 30, 1996, and the related combined statement of operations and changes in net position for the fiscal year (FY) ended September 30, 1996 (principal financial statements). These financial statements are the responsibility of HCFA's management and include the accounts of all funds it administers: the Medicare hospital insurance (HI) trust fund, the Medicare supplementary medical insurance (SMI) trust fund, and Medicaid grants.

Except for the following limitations on the scope of our work on the principal financial statements, we did our work in accordance with generally accepted government auditing standards and Office of Management and Budget (OMB) Bulletin 93-06. Because of the significance of the following matters and because we were not able to apply necessary auditing procedures to satisfy ourselves as to the fair presentation of the financial statements taken as a whole, the scope of our work was not sufficient to enable us to express, and we do not express, an opinion on the principal financial statements:

- ***Medicare Accounts Payable.*** As of September 30, 1996, reported Medicare accounts payable totaled $36.1 billion and comprised 71 percent of total liabilities. These payables represent HCFA's estimate of actual or potential claims for services provided to beneficiaries but not paid at the end of the FY. The HCFA did not provide adequate support for this estimate. Additionally, we were unable to determine, through alternative audit procedures, if the September 30, 1996, Medicare accounts payable balance

was fairly presented. Specifically, we could not find support for $18.3 billion of the accounts payable amount using historical claims data adjusted for costs associated with interim payments to providers and settlements from providers' cost reports. Moreover, using expenditure trends to assess the reasonableness of the payables estimate, we noted that Medicare expenditures increased 16 percent while the accounts payable increased 64 percent. Historically, when compared with expenditures, the payables had erratic and inconsistent changes which HCFA could not explain.

- ***Supplementary Medical Insurance Revenue.*** The Social Security Administration is responsible for withholding premiums from SMI beneficiaries' Social Security checks and for transferring these funds to the Part B trust fund each month. Premiums collected from beneficiaries, which also include collections from other sources, totaled $18.9 billion in FY 1996. These premiums were matched by a $61.7 billion contribution from the Federal Government. The Congress sets the premium rate based on data provided by the HCFA actuary. We did not review the rate setting process, nor has the SMI revenue been audited. Further, the Office of Inspector General (OIG), Department of Health and Human Services (HHS), lacks statutory authority to audit another Federal agency. As such, we were unable to determine whether the SMI revenue account of $18.9 billion, as well as the Federal match of $61.7 billion, which is material to HCFA's statement of operations, was fairly presented.

- ***Medicare/Medicaid Accounts Receivable.*** Reported net Medicare accounts receivable totaling $2.68 billion at September 30, 1996, are amounts providers owe due to overpayments. Medicare contractors did not maintain adequate documentation to support reported accounts receivable activity and to provide adequate audit trails. At several contractor locations, millions could not be reconciled to contractor-reported amounts. As a result, we could not audit the accounts receivable balance because contractors could not support amounts reported to HCFA and because contractors inconsistently applied HCFA accounting policies. In addition, we were unable to perform sufficient procedures to satisfy ourselves on the reasonableness and accuracy of the Medicaid accounts receivable.

Currently, States reported only an estimated $400 million as receivables, and we are concerned that this could be substantially understated.

- ***Cost Report Settlements.*** Part A providers are paid interim amounts throughout the year and subsequently file a cost report to reconcile actual costs to the interim payments received. In FY 1996, approximately 37,700 cost reports were due from providers. The value of the Medicare payments to all institutional providers for FY 1996 was about $125 billion. Typically, these payments will not be settled for 2 years. Although HCFA does have a cost report audit process, the provider audit function is limited to specific issue areas or cost report line items and covers only a limited number of providers. Due to the limited scope of the contractors' provider audit function, there is no assurance that amounts eventually paid to providers through the final cost report settlement process meet Medicare guidelines for reasonableness and appropriateness. Therefore, we were unable to determine what adjustments, if any, were necessary to the $3 billion in cost settlements from prior years, as well as any subsequent adjustments that may be necessary to the cost reports filed for the FY 1996 financial statements.

We also note that HCFA's financial statements include investment and interest activity which is reported to HCFA by the United States Treasury. Our audit scope was limited to determining the correct recording of the amounts reported by Treasury.

With respect to the FY 1995 statements which are being presented for comparative purposes, we were unable to satisfy ourselves as to Medicare accounts receivable and accounts payable balances and Medicaid accounts receivable and accounts payable balances. Accordingly, we do not express an opinion on the FY 1995 statement of position. The FY 1995 statement of operations and changes in net position was not audited by us, and we do not express an opinion.

The HCFA's Financial Report. The financial information presented in *HCFA's FY 1996 Financial Report,* including the management overview, is supplemental information required by OMB Bulletin 94-01 and is not a required part of the principal financial statements. This information, which includes trust fund

projections, has not been subjected to audit procedures. Accordingly, we express no opinion on it.

REPORT ON COMPLIANCE WITH LAWS AND REGULATIONS

Compliance with laws and regulations applicable to HCFA is the responsibility of HCFA's management. We performed tests of HCFA's compliance with certain provisions of the following laws and regulations. However, our objective was not to provide an opinion on overall compliance with such provisions. Accordingly, we do not express such an opinion.

- Title XVIII and XIX of the Social Security Act, as amended, and implemented in regulation 42 of the Code of Federal Regulation (CFR);
- Chief Financial Officers (CFO) Act of 1990;
- Government Management Reform Act of 1994;
- Federal Managers' Financial Integrity Act (FMFIA) of 1982;
- Anti Deficiency Act;
- Prompt Payment Act;
- Civil Service Reform Act of 1978, as amended;
- Civil Service Retirement Act of 1930;
- Fair Labor Standards Act;
- Federal Employees Compensation Act;
- Budget Accounting and Procedures Act of 1950;
- Single Audit Act of 1984;
- Federal Employees Group Life Insurance Act of 1980; and
- Federal Employees Retirement System Act of 1986.

Material instances of noncompliance are failures to follow applicable laws and regulations to the extent that the effects of such noncompliance, in the aggregate, cause the financial statements to be misstated. The results of our tests of compliance disclosed a material instance of noncompliance. The estimated net effect of the following material noncompliance issue has been reflected in HCFA's FY 1996 financial statements.

Medicare Fee-for-Service Payments Made Under Title XVIII of the Social Security Act

The Medicare program is inherently vulnerable to incorrect provider billing practices. Through detailed medical and audit review of a statistical selection of 600 beneficiaries nationwide with 5,314 fee-for-service claims processed for payment during FY 1996, we found 1,577 that did not comply with Medicare laws and regulations. By projecting these sample results, we estimate that during FY 1996 net overpayments totaled about $23.2 billion nationwide, or about 14 percent of total Medicare fee-for-service benefit payments. These improper payments could range from inadvertent mistakes to outright fraud and abuse. We cannot quantify what portion of the error rate is attributable to fraud. Specifically, 99 percent of the improper payments in our sample were detected through medical record reviews coordinated by the OIG in conjunction with medical personnel. When these claims were submitted for payment to Medicare contractors, they contained no visible errors. Although HCFA has recognized the need to reduce Medicare overpayments, a system is needed to objectively measure the amount of improper payments so that performance can be measured and corrective action taken promptly.

Audit Objective

The complexity of HCFA's reimbursement systems and policies, the reported instances of fraud and abuse, and the decentralized structure of the Medicare program contributed to the OIG's preliminary assessment of high inherent and control risk in the FY 1996 Medicare benefit payment expenses. As a result, we placed limited reliance on HCFA's internal control structure and expanded our testing to be reasonably sure of detecting material misstatements in the determination of financial statement amounts.

Our primary objective was to determine whether Medicare benefit payments were made in accordance with the provisions of Title XVIII and implementing regulations in 42 CFR for services that were:

- furnished by certified Medicare providers to eligible beneficiaries;
- reimbursed by Medicare contractors in accordance with Medicare laws and regulations; and
- medically necessary, accurately coded, and sufficiently documented in the beneficiaries' medical records.

Audit Methodology

Statistical Selection Method. To accomplish our objective, we used a multistage stratified sample design. The first stage consisted of a random selection of 12 contractor quarters during FY 1996. Our sample frame consisted of 236 quarters (59 contractors x 4 quarters). The selection was based on probability-proportional-to-size using Rao, Hartley, Cochran methodology. We used FY 1995 Medicare fee-for-service benefit payments as the selection weighting factors. For the 12 contractor quarters, 10 contractors were included (2 contractors were included twice). Of the 10, 5 are both fiscal intermediaries (FIs) and carriers, 4 are FIs, and 1 is a carrier. The FIs process payments for hospitals, skilled nursing facilities (SNFs), home health agencies (HHAs), rural health clinics, hospices, end stage renal disease facilities, and other institutional type providers. Carriers process payments to physicians, clinical laboratories, free-standing ambulatory surgical centers, and other noninstitutional providers.

The second stage consisted of a random sample of 50 beneficiaries from each contractor quarter stratified into 4 strata by total amount of payments for services. The random sample of 600 beneficiaries produced 5,314 claims for review valued at $5.2 million. To ensure the completeness of the claims data, we reconciled Medicare contractor claims data to the HCFA 1522 Monthly Financial Report for the 12 contractor quarters selected. The HCFA used this report to assist in its preparation of the FY 1996 financial statements.

We used a variable appraisal program to estimate the dollar impact of improper payments in the total population. The population represented $168.6 billion in fee-for-service payments.

Audit Procedures. We reviewed all claims processed for payment for each selected beneficiary during the 3-month period. Specifically, we used medical review personnel from HCFA's Medicare contractors and peer review organizations (PROs) to assess the medical records and to determine whether the services billed were reasonable, medically necessary, adequately documented, and coded correctly in accordance with Medicare reimbursement rules and regulations. Each provider selected in our sample was contacted by letter requesting copies of all medical records supporting services billed. In the event that we did not receive a response from our initial letter, followup contacts were made by a second letter and, in most instances, by additional telephone calls. Throughout the medical review, we coordinated OIG and medical review efforts to ensure consistency and accuracy. Concurrent with the medical review, we made additional detailed claims reviews, focusing on past improper billing practices, to determine whether:

- the contractor paid, recorded, and reported the claim correctly;
- the beneficiary and the provider met all Medicare eligibility requirements;
- the contractor did not make duplicate payments or payments for which another primary insurer should have been responsible (Medicare secondary payer); and
- all services were subjected to applicable deductible and co-insurance amounts and were priced in accordance with Medicare payment regulations.

Results of Review

Our review indicates that the Medicare program is inherently vulnerable to incorrect provider billing practices. Through detailed medical and audit review of

a statistical selection of 600 beneficiaries nationwide with 5,314 fee-for-service claims processed for payment during FY 1996, we found 1,577 that did not comply with Medicare laws and regulations. The contractors in these cases specifically disallowed and already recovered many of the overpayments identified in our sample, consistent with their normal claims adjudication process.

We estimate the point estimate dollar value of improper Medicare benefit payments made during FY 1996 to be $23.2 billion, or about 14 percent of the $168.6 billion in processed fee-for-service payments reported by HCFA. The estimated range of the improper payments at the 95 percent confidence level is $17.8 billion to $28.6 billion, or about 11 percent to 17 percent.

As noted in the following chart, most of the errors in our sample fell into four general categories:

- Documentation, which includes both insufficient and no documentation;
- Lack of medical necessity;
- Incorrect coding; and
- Noncovered/unallowable services.

Estimated Amount of Improper Payments (By Type of Error)

Type of Improper Payment	Estimated Dollars In Improper Payments *(in millions)*	Improper Payments as a Percent of Total
Documentation:	**$10,846**	**46.76%**
Insufficient Documentation	*7,596*	*32.75%*
No Documentation	*3,250*	*14.01%*
Lack of Medical Necessity	**8,529**	**36.78%**
Incorrect Coding	**1,978**	**8.53%**
Noncovered or Unallowable Services	**1,219**	**5.26%**
Other	**620**	**2.67%**
Total	**$23,192**	**100.00%**

A further breakdown of these errors shows that 88 percent of the $23.2 billion occurred within the first 6 provider types below:

Estimated Amount of Improper Payments (Based on Point Estimate)

	Types of Error (in millions)							
Type of Claim	*Lack of Medical Necessity*	*Insufficient Documentation*	*No Documentation*	*Incorrect Coding*	*Non-covered/ Unallowable Service*	*Remaining Errors*	*Total*	*Percentage of Improper Payments*[4]
Inpatient PPS	$3,301	$869	$171	$900		($2)[1]	$5,239	22.59%
Physician	614	1,940	816	1,070	$329	258	5,027	21.68%
Home Health Agency	1,935	1,681	3			31	3,650	15.74%
Outpatient	356	1,381	905	1	85	82	2,810	12.12%
Skilled Nursing Facility	1,365	555	501			3	2,424	10.45%
Laboratory	146	329	844	(14)[2]	30	2	1,337	5.76%
Subtotal	$7,717	$6,755	$3,240	$1,957	$444	$374	20,487	88.34%
Hospice		179			763		942	4.06%
Inpatient Non-PPS	606					18	624	2.69%
End Stage Renal Disease	24	367				226	617	2.66%
Transportation	181	123	4	3	2		313	1.35%
Ambulatory Surgery	1	172	6	18	10	2	209	0.90%
Total	$8,529	$7,596	$3,250	$1,978	$1,219	$620	$23,192[3]	100.00%
Percentage of Improper Payments[5]	36.78%	32.75%	14.01%	8.53%	5.26%	2.67%		

1 *Negative dollars represent claims that were reimbursed using a rate lower than supported.*
2 *Negative dollars represent claims that were reimbursed using a procedure code level lower than supported.*
3 *Range of improper payments at the 95 percent confidence level is $17.781 billion to $28.603 billion. Each dollar estimate is computed consistent with the sampling methodology. The sum of all the dollar estimates equals the overall estimate of $23.192 billion.*
4 *Percentage of the overall estimate of $23.192 billion by the type of claim.*
5 *Percentage of the overall estimate of $23.192 billion by the type of error.*

Each dollar estimate in the previous chart was computed using a method similar to projecting the overall dollar error rate. However, the precision of the dollar estimate by specific type of claim and type of error is not sufficient to use for benchmarking purposes. This would have required an expenditure of audit resources outside the scope of a financial statement audit.

As noted in the chart, 88 percent of our point estimate of improper payments ($20.487 billion) from our sample results occurred in the following provider types:

- **Inpatient Prospective Payment System (PPS)**
- **Physician**
- **Home Health Agency**
- **Outpatient**
- **Skilled Nursing Facility**
- **Clinical Laboratory**

In addition to identifying the errors by provider type, we analyzed the types of errors, as discussed below:

☛ **Lack of Documentation**

The most pervasive errors for these six provider types were insufficient or no documentation. These 2 error categories accounted for about $10 billion ($6.755 billion for insufficient documentation and $3.240 billion for no documentation), or about 43 percent, of the $23.2 billion in improper payments. As previously indicated, if providers failed to provide documentation or submitted insufficient documentation, the contractors generally requested supporting medical records three times before determining the payment to be improper. Medicare regulation, 42 CFR 482.24(c), specifically requires providers to maintain medical records that

contain sufficient documentation to justify diagnoses, admissions, treatments performed, and continued care.

Some examples of documentation problems follow:

- **SNF.** A hospital-based SNF was paid $9,365 for a 25-day skilled nursing stay by a 79-year-old patient. The contractor's medical review staff determined that the patient's medical records did not support the provision of skilled nursing care. Medical records documented that the patient received only maintenance-level (nonskilled) nursing home care. Medicare does not reimburse nonskilled services, such as assisting a patient with daily living or meeting personal needs, that could be provided safely by individuals without professional skills or training.

- **Physician.** A physician billed Medicare for 10 hospital visits during a beneficiary's hospital stay and was paid $523. The medical records provided by the physician did not contain support for 8 of the 10 visits. As a result, the medical reviewers concluded that the payments for the other eight visits were not supported, resulting in a $386 overpayment.

- **Clinical Laboratory.** One claim for clinical laboratory services, which included six procedures for automated blood tests, was reimbursed for $64. The medical records did not contain, as required, doctor's orders for the laboratory services billed, nor did they annotate that blood was drawn for testing. As a result, the medical reviewer recommended the claim be denied due to insufficient documentation.

Lack of Medical Necessity

A lack of medical necessity was the second highest error category. For these 6 provider types, a lack of medical necessity accounted for $7.717 billion, or 33 percent, of the $23.2 billion in improper payments. These decisions were made by the contractor or PRO medical review staff using Medicare reimbursement rules and regulations. They followed their normal claims review procedures to determine whether the medical records supported the Medicare claims. Their

findings show that in these cases, based upon the review of the medical records, the services as billed were not medically necessary.

Some examples include:

- **Inpatient.** An acute care hospital received $5,367 to perform certain diagnostic tests that did not require a hospital stay. Based on a medical review, the patient did not have medical conditions justifying the hospital admission. The medical workup, x-rays, bone scan, and consultation could have been carried out in an outpatient setting. Accordingly, the medical reviewer deemed the services medically unnecessary and disallowed the entire payment.

- **SNF.** A SNF received $15,362 for 61 days of care. This payment represented room/board, respiratory therapy services, and other miscellaneous supplies. Based on the medical review, this claim was denied because the medical records did not document a chronic illness or condition necessitating a skilled level of care. The medical reviewer indicated that the patient was stable and that the provider should have known that a skilled service was not necessary. Accordingly, the reviewer disallowed the entire payment.

- **HHA.** An HHA's $11,790 claim for skilled physical therapy, skilled nursing care, and home health aide services was denied because the services were medically unnecessary. The medical reviewer noted that the beneficiary, a resident of a board and care facility, had no functional diagnosis requiring physical therapy or skilled nursing care. The primary diagnosis, according to the medical records, was a "small wound on wrist."

  Another HHA received payment of $1,528 for home health services which were not medically necessary because the services were custodial (care to assist patients with daily living or meeting personal needs) in nature and did not require any skilled care. Therefore, the medical reviewer disallowed the entire claim.

- **Clinical Laboratory.** On August 29, 1996, a laboratory provider billed Medicare for blood work-up without having any diagnosis or specific medical condition for the patient. Further, the ordering physician had not seen the patient since January 18, 1996.

- **Physician.** A physician received a $98 payment for interpretation of an echocardiography performed on December 19, 1995. According to the medical records submitted, a cardiology consultation performed on December 1, 1995, indicated no further followup was necessary. The medical reviewer determined these services were not medically necessary.

☛ Incorrect Coding

Incorrect coding is the third highest error category for these 6 provider types and accounts for $1.957 billion, or about 8.4 percent, of the $23.2 billion in improper payments. Two of the six provider types (inpatient PPS and physician) account for most of the improper payments. Of the remaining four provider types, two types, HHA and SNF, are paid using per diem rates applied to the number of services rendered, not the level of service rendered. Therefore, they do not have coding errors. Incorrect coding for outpatient and laboratory services was immaterial.

The medical industry uses a standard coding system to bill Medicare for services provided. For most of the coding errors, the contractor medical review staff determined that the documentation submitted by the provider supported a lower reimbursement amount. However, we did find a few instances of downcoding which were offset against identified upcoding situations.

Examples of incorrect coding follow:

- **Inpatient Hospital.** One beneficiary had three separate hospital inpatient admissions during a 3-month period. Medicare paid $8,533 for each admission under one pulmonary diagnosis-related group (DRG). Based on the review of medical records, the medical reviewer concluded that all three claims should have been paid under a less extensive pulmonary DRG that paid at $6,290. This resulted in reducing each claim by $2,243, or a total overpayment of $6,729.

- **Physician.** A physician billed Medicare for a hospital emergency room visit for "treatment of a medical problem of high severity that requires urgent evaluation by the emergency room physician." According to the medical reviewer, the medical records submitted by the provider did not support the level of service billed but rather "treatment for medical problems of moderate severity."

  Another physician billed Medicare for subsequent hospital care requiring "a medical decision of high complexity by the provider" when it should have been for medical care "that is straightforward or of low complexity."

☛ Noncovered/Unallowable Services

Unallowable services for these 6 provider types account for $444 million, or about 1.9 percent, of the $23.2 billion in improper payments. Medicare unallowable services are defined as those that Medicare will not reimburse because the services do not meet Medicare reimbursement rules and regulations. According to the 1996 Medicare Handbook, the following services are not covered by Medicare Part B:

- most routine physical examinations and tests directly related to such examinations;

- eye or ear examinations to prescribe or to fit glasses or hearing aids;

- most immunizations;
- most prescription drugs;
- blood transfusions furnished on an outpatient basis;
- most routine foot care; and
- chiropractic services, unless the services are for the manipulation of the spine to correct a subluxation demonstrated by x-ray.

Following are some examples of noncovered or unallowable services identified during our review:

- **Physician Claims.** A physician billed Medicare for an electrocardiogram and various laboratory tests. After reviewing the medical records submitted by the provider, the medical reviewer concluded the billed services should be denied because the services were performed as part of the beneficiary's routine yearly physical examination, which is not a Medicare-covered service.

- **Hospital Outpatient.** A patient was evaluated for foot orthotics, and impressions were taken to make soft arch supports. Arch supports are not covered by Medicare. Although the patient signed a hospital form acknowledging that arch supports were not covered by Medicare, the claim was billed as though it were a Medicare-covered service.

- **SNF Services.** Most of the errors occurred when the SNFs billed Medicare separately for various routine services already included in its flat-rate reimbursement.

Conclusions and Recommendations

The HCFA uses numerous prepayment and postpayment safeguards to prevent or detect improper Medicare benefit payments. For instance, prepayment edits help ensure that billed services are paid accurately and timely, but these controls cannot always detect medically unnecessary, never-rendered, or miscoded services. The HCFA's postpayment medical review is generally effective for identifying abuse and overutilization and for detecting payments for unsubstantiated, medically unnecessary, and noncovered services. However, funding limitations have significantly constrained medical review to the extent that currently only about 3 of every 1,000 providers are subjected to postpayment medical review audit. As our results indicate, a significant opportunity exists for providers to:

- bill for services that are excessive or not medically necessary,
- bill for services that are unsubstantiated per the beneficiary's medical record, and
- improperly code services to obtain higher Medicare payment than the appropriate code would permit.

In view of Medicare's 38 million beneficiaries, 800 million claims processed and paid annually, complex reimbursement rules, decentralized operations, and health care consumers who may not be alert to improper charges, the Medicare program is inherently at high risk for payment errors. Due to limited funding, resources devoted to prepayment and postpayment review have not kept pace with the increase in claims or providers' questionable billing practices. However, even the best developed prepayment and postpayment controls at the contractor level may not be sufficient to prevent or detect material Medicare program losses resulting from excessive, unnecessary, or unsubstantiated provider services. Therefore, HCFA needs to consider stronger deterrents to reduce improper benefit payments.

Medicare, like other insurers, makes payments based on a standard claim form. Providers are required to retain supporting documentation and make it available upon request. However, a significant portion of the errors we found were

attributable to a lack of or insufficient documentation on the part of providers that claimed payments.

As demonstrated in our review, unnecessary or improper benefit payments continue to plague the Medicare program. Existing risks are sharply increased by the significant growth in Medicare claims and expenditures, the inherent complexities of the Medicare program, and restricted funding for program safeguards to deter abusive providers. Our review has also demonstrated the need for stronger oversight by HCFA to ensure provider compliance with Medicare reimbursement rules and regulations. Recommendations on this issue are detailed on page 21. In addition, among the more important issues HCFA faces in the immediate future is preserving the solvency of the Medicare trust funds.

As part of its strategic plan to safeguard these funds, we recommend that HCFA:

① Develop and implement stronger deterrents to reduce improper Medicare benefit payments.

② Enhance prepayment and postpayment controls by updating computer systems and related software technology to better detect improper Medicare claims.

③ Expand payment safeguard activities and, if necessary, seek additional funding.

④ Direct contractors to expand provider training to further emphasize the need to maintain medical records that contain sufficient documentation and the penalties for not doing so.

⑤ Ensure that contractors recover improper payments identified in our review.

⑥ Direct that contractors follow up with specific providers identified in our sample to address documentation and medical necessity concerns and to determine whether other systemic problems need to be corrected.

⑦ Direct contractors to make followup evaluations of specific procedure codes with high error rates.

REPORT ON INTERNAL CONTROLS

In accordance with OMB Bulletin 93-06, we obtained an understanding of the design of relevant internal control policies and procedures. Except for control policies and procedures relating to performance measurement data, we made sufficient tests of HCFA's internal control structure policies and procedures deemed to have been properly designed and placed in operation to justify a low assessed level of control risk. The purpose of this work was to determine auditing procedures necessary for expressing an opinion on the financial statements, not to provide assurance on the overall internal control structure. Accordingly, we do not express such an opinion.

Because of inherent limitations in any internal control structure, errors or irregularities may occur without detection. Also, projection of any evaluation of the internal control structure to future periods is subject to the risk that procedures may become inadequate if conditions change or if the effectiveness of the design and operation of policies and procedures deteriorates.

The HCFA's management is responsible for establishing and maintaining an internal control structure. In fulfilling this responsibility, management makes estimates and judgments of the expected benefits and costs of internal control structure policies and procedures. The objectives of an internal control structure are to provide management with reasonable, but not absolute, assurance that:

- transactions are properly recorded and accounted for to permit the preparation of reliable financial statements and to maintain accountability over assets;
- funds, property, and other assets are safeguarded against loss from unauthorized use or disposition; and

- transactions, including those related to obligations and costs, are in compliance with laws and regulations that could have a direct and material effect on the principal financial statements and that OMB, HCFA, or we have identified as significant for which compliance can be objectively measured and evaluated.

Reportable conditions involve matters coming to our attention relating to significant deficiencies in the design or operation of the internal control structure that, in our judgment, could adversely affect the entity's ability to record, process, summarize, and report financial data consistent with management's assertions in the financial statements.

Material weaknesses are reportable conditions in which the design or operation of one or more internal control structure elements does not reduce to a relatively low level the risk that errors or irregularities in amounts that would be material in the financial statements may occur and not be detected within a timely period by employees during the normal course of their duties.

We noted six internal control weaknesses that we consider to be reportable conditions under standards established by the American Institute of Certified Public Accountants and OMB Bulletin 93-06. We believe that four of these reportable conditions are also material weaknesses as defined above. Two of these material weaknesses (Medicare accounts receivable and accounts payable) were reported in previous CFO audit reports[1] and remain uncorrected. The internal control weaknesses discussed in this report were not identified as material weaknesses by HCFA in the HHS FY 1996 FMFIA report.

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[1] *Final reports entitled: "Report on the Health Care Financing Administration's Internal Control Structure and Compliance with Laws and Regulations for the Fiscal Year Ended September 30, 1993" (CIN: A-14-93-03027) dated September 29, 1994; "Inspector General's Report on the Health Care Financing Administration's Combined Financial Statements" (CIN: A-17-94-03032) dated June 30, 1995; "Report on the Health Care Financing Administration's Internal Control Structure Over Medicare Accounts Receivables for the Fiscal Year Ended September 30, 1994 (CIN: A-01-94-00520) dated August 7, 1995; and "Inspector General's Report on the Health Care Financing Administration's Combined Financial Statements" (CIN: A-17-95-00051) dated June 18, 1996.*

MATERIAL WEAKNESSES

Monitoring National Compliance

The HCFA processes an estimated 800 million claims on behalf of its 38 million beneficiaries through a complicated decentralized system involving 59 contractors and multiple shared systems. Because of the inherent risk of improper payments and the 10 percent estimate of fraud, waste, and abuse reported by the U.S. General Accounting Office (GAO), we developed the first national Medicare improper payment error rate. Based on our FY 1996 audit of HCFA's financial statements, we estimate that improper payments approximate $23.2 billion nationwide, or about 14 percent of total Medicare fee-for-service benefit payments. These errors could range from inadvertent mistakes to outright fraud and abuse. We cannot quantify what portion of the error rate is attributable to fraud. Considering the significance of the error rate, we conclude that HCFA's oversight of the Medicare program does not provide reasonable assurance of detecting and preventing improper Medicare payments. Therefore, this constitutes a material weakness which requires prompt corrective actions. First and foremost, HCFA needs to develop a national error rate for the following reasons:

- to disclose, for financial reporting, Medicare expenditures that do not conform to Medicare reimbursement principles;
- to determine specific corrective actions for controlling improper payments; and
- to develop national performance measurements for error rate reduction and control.

The HCFA's claims processing controls were generally adequate for (1) ensuring beneficiary and provider Medicare eligibility, (2) pricing claims based on information submitted, and (3) ensuring the services billed were allowable under Medicare rules and regulations. However, these controls were not effective in detecting the types of errors discussed on page 8. As previously noted, Medicare,

like other insurers, makes payments based on a standard claim form. Providers are required to retain supporting documentation and make it available upon request.

Because of resource considerations, HCFA placed more emphasis on prepayment reviews, and thus contractors used a variety of software to target medical review efforts on suspect claims. We recognize that HCFA cannot perform "look behind" medical reviews on all claims. However, current controls do not prevent or detect significant Medicare program losses resulting from excessive, unnecessary, or unsubstantiated provider services. Therefore, HCFA must take a more proactive role by focusing on an extensive postpayment analysis of claims to identify the most aberrant procedures and services resulting in improper payments.

We believe that prepayment edits and look-behind medical reviews are the most important tools to detect and prevent improper payments. Currently, such factors as a contractor's budget and workload influence the number of prepayment edits and the extent of look-behind medical reviews. Because of the significance of the national error rate, HCFA needs to take aggressive steps to strengthen controls over monitoring the integrity of claims. Accordingly, HCFA should consider additional prepayment edits and look-behind reviews to detect and prevent the improper payments noted in our review.

In addition to recommendations on pages 17 and 18, we recommend that HCFA:

① Develop a system that estimates improper payments objectively and periodically and disclose the range of such payments in its financial statements.

② Develop a national error rate to focus corrective actions and measure performance in reducing improper payments.

③ Report the lack of a national error rate process as a material internal control weakness in the HHS FY 1997 FMFIA report.

④ Continue to update its systems' capabilities to keep pace with questionable billing practices.

Medicare Accounts Payable

As previously discussed, we were unable to determine the reasonableness of the Medicare accounts payable balance totaling $36.1 billion at September 30, 1996. The first analysis that we made to determine the reasonableness of the payables estimate was to compare FYs 1992-1996 expenditures with accounts payable data. There should be a direct relationship between Medicare expenditures and estimated unpaid claims at yearend.

As noted in the chart below, the account payable estimate showed erratic and inconsistent changes compared with expenditures:

Medicare Accounts Payable and Claim Expenditures

FY	Accounts Payable Percent Change	Claim Expenditures Percent Change
1993	-11%	6.0%
1994	77%	24.0%
1995	-12%	.7%
1996	64%	16.0%

Our next analysis was a comparison of actual claims data for services rendered but not paid at yearend with HCFA's actuarial estimate of accounts payable. The HCFA's acturial estimate for the Medicare accounts payable liability was developed as a byproduct of the long-term trust fund projections, not as a separate analysis for financial reporting. According to HCFA, trust fund projections are based on actual claims, nonclaims payments, and a variety of trends. One of the key ingredients HCFA uses for the payables estimation process is paid claims data from its National Claims History (NCH) file. Although we did not audit the completeness or validity of the NCH file, we obtained monthly NCH reports on current-year payments for services provided in past FYs. This should represent the majority of the yearend liability of unpaid claims.

We compared HCFA's FY 1993-1996 payables estimates with NCH data. As noted below, we found significant differences between these estimates and actual claims data. The HCFA could not explain these differences.

Comparison of Estimates of Accounts Payable Liability

FY	HCFA's Actuarial Estimate (in billions)	Claims History (in billions)	Difference (in billions)
1993	$14.1	$11.2	$2.9
1994	24.9	13.4	11.5
1995	22.0	13.7	8.3
1996	36.1	17.8	18.3

In addition, by contract with an actuary, we reviewed HCFA's FY 1996 Medicare accounts payable estimate. The actuary identified a $4.5 billion computation error in the accounts payable estimate. This error increased the reported Medicare accounts payable 14 percent.

In our opinion, HCFA's method of estimating the Medicare accounts payable is inadequate for accurate accrual-based financial statements and constitutes a material internal control weakness.

Recommendations

We recommend that HCFA:

① Revise its method of estimating Medicare accounts payable to more correctly reflect services provided but not paid at yearend and periodically reconcile the estimate to paid claims data.

② Report the lack of an acceptable method for estimating Medicare accounts payable for financial statement reporting purposes as a material weakness in the HHS FY 1997 FMFIA report.

Need for Improved Financial Management Controls

The OMB Bulletin 94-01 requires that financial statements be the culmination of a systematic accounting process. The HCFA does not have an integrated accounting system that captures Medicare contractor expenditures. Instead, HCFA relies on a complex reporting system and ad hoc reports to accumulate financial data.

At selected Medicare contractors, we noted millions of dollars in unsupported or unrecorded transactions. This problem was caused by the lack of an integrated accounting system linking the HCFA central office to the Medicare contractors. For example, current systems did not contain normal accounting system features, such as a double-entry general ledger system, proper cutoff procedures, and adequate source documentation. As a result, contractors do not have accounting systems that record, classify, and summarize information for the preparation of financial statements. These weaknesses increase the risk of material misstatement in the financial statements. Moreover, HCFA's oversight of financial management controls has not provided reasonable assurance that material errors would be detected in a timely manner.

Details on these matters follow.

☛ **Medicare Accounts Receivable**

As previously noted, we were unable to satisfy ourselves as to the reasonableness and accuracy of the $2.68 billion in Medicare accounts receivable at September 30, 1996. These are amounts owed Medicare by providers who were overpaid. The OIG previously reported that the internal controls over Medicare accounts receivable processing were not adequate. These problems continue, despite HCFA's efforts to implement financial core requirements and to provide training to ensure that contractors report their financial data in conformance with the CFO Act. Contractors did not have adequate controls or consistently apply

HCFA's accounting policies. Therefore, they did not properly estimate accounts receivable, maintain adequate documentation to support accounts receivable activity, or reconcile reported amounts with subsidiary records.

As discussed below, similar problems were noted in our current review:

- Medicare contractors did not adequately document reported accounts receivable activity or provide adequate audit trails. At one contractor location, approximately $7 million could not be reconciled to reported amounts.

- Some Medicare Part A providers are paid on an interim basis using prior claims activity and related costs (referred to as the periodic interim payment (PIP) method of reimbursement). We found that some contractors used inconsistent accounting procedures to calculate receivables and payables resulting from the PIP reimbursement process. For instance, one contractor incorrectly included $700 million as a receivable when in fact all but $32 million was a payable. Also, four contractors did not record either PIP receivables or payables. One additional contractor included a $25 million PIP payable rather than an $80 million PIP receivable.

- Medicare contractors did not always reconcile the amounts reported on HCFA's Provider Overpayment Report (POR) with the quarterly 750/751 Report. For example, for the same reporting period, a contractor reported accounts receivable of (1) $121.4 million on its HCFA 750, (2) $150 million on its POR, and (3) $112.1 million on its "STOP" report. This contractor was unable to reconcile these variances and determine the true accounts receivable.

- Some Medicare contractors did not maintain an audit trail to ensure that cash collected from overpayments was properly recorded in the individual accounts receivable records. In addition, the receivables sometimes were not adjusted until months after the cash was collected.

As a result of these accounts receivable control weaknesses, HCFA may not be collecting millions of dollars in overpayments from providers. These problems have been addressed in HCFA's corrective action plan for FY 1997 and future years.

☛ Controls Over Cash

We reviewed the contractors' cash procedures to determine whether safeguards were adequate, records were in place, and duties were properly segregated. These controls typically are designed to protect assets against theft, loss, misuse, or unauthorized alteration and to reduce the opportunities for perpetrating and concealing errors or irregularities. Based on our internal control work, we identified the following weaknesses:

- The separation of duties was inadequate. In this regard, the same individual was responsible for receiving and endorsing checks, preparing and recording deposits, and performing bank reconciliations (two contractors).
- The amount reported as outstanding checks on the HCFA 1522 could not be supported by documentation (five contractors).
- General ledgers or subsidiary ledgers supporting cash balances were not maintained (seven contractors).
- Supervisory review of bank reconciliations was not performed (three contractors).
- Check signature lists contained unauthorized contractor personnel (two contractors).
- Contractor time account balances totaling about $59 million initially were not included in HCFA's accounting records.

☛ Financial Reporting and Reconciliations

The reconciliation of "total funds expended" on the HCFA 1522, Monthly Contractor Financial Report, is an important control which ensures that all amounts reported to HCFA by Medicare contractors are accurate, supported, complete, and properly classified. At the Medicare contractor level, "total funds expended" is the sum of all checks drawn and electronic fund transfer payments issued during the calendar month less voided checks and overpayment recoveries. This amount is then further classified by component into the following categories: benefit payments, PIP, accelerated payments, net suspense payments, audit reimbursement adjustments, and interest income and expenses. The HCFA uses the information from this report in preparing its financial statements.

Our analysis of the HCFA 1522 report at the 10 selected Medicare contractors identified the following internal control weaknesses:

- Paid claim activity and "total funds expended" were not formally reconciled. For example, it took several months for the contractors to produce payment tapes that summarized individual claim transactions, to identify adjusting entries, and to establish proper cutoff periods that reconciled with the monthly HCFA 1522.

- The contractors had no internal written policies or procedures for preparing the HCFA 1522.

- In many cases, readily available general ledgers and appropriate subsidiary records were not maintained to support all components of "total funds expended" on the HCFA 1522. For example, to prepare the monthly HCFA 1522 reports, contractors had to obtain data from various sources, such as the computerized claims processing system, bank statements, manually prepared documents and ledgers, and estimates. This data was then manually combined by contractors' accountants into the HCFA reporting formats. However, the source documents were not always maintained or available.

- Some contractors did not subject the HCFA 1522 to independent verification. One contractor had an incorrect allocation of PIP payments between the HI and SMI trust funds, resulting in a $360 million classification error.

Although we noted similar weaknesses in our prior internal control reports issued to HCFA, contractors have not effectively implemented the controls necessary to ensure adequate financial reporting.

Recommendations

To correct the conditions addressed above, we recommend that HCFA:

① Review and monitor the accounts receivable internal control structure to provide reasonable assurance that reported amounts are valid and documented. For example, the HCFA regional offices and/or outside independent audit firms could assess the adequacy of controls.

② Establish an integrated financial management system to promote consistency and reliability in recording and reporting accounts receivable information.

③ Ensure that all contractors establish a general ledger system that incorporates double-entry bookkeeping.

④ Ensure that all contractors develop control procedures to provide independent checks to ensure the validity, accuracy, and completeness of the amounts reported to HCFA, including a reconciliation with the contractors' supporting documentation.

⑤ Ensure that contractors receive ongoing training on the HCFA 750/751 report.

⑥ Include the issues relating to financial management discussed in this report in the HHS FY 1997 FMFIA report.

MATERIAL WEAKNESS/REPORTABLE CONDITION

Medicare Electronic Data Processing Controls

We considered several electronic data processing (EDP) control weaknesses at the HCFA central office, selected Medicare contractor locations, Common Working File (CWF) host sites, the CWF maintainer, and shared system maintainers to be reportable conditions. We considered the control weaknesses at the HCFA central office to be material.

Background

To administer the FY 1996 Medicare program and to process and account for $204 billion in Medicare expenditures, HCFA relied on extensive data processing operations at both HCFA and fiscal contractors that process Medicare claims. The HCFA central office computer center primarily maintains administrative data, such as Medicare enrollment, eligibility, and paid claims data, but it also processes all payments for managed care.

Medicare contractors use one of several "shared" systems to process and pay fee-for-service claims. As part of the claims processing, these systems interface with the CWF to obtain authorization to pay claims. The CWF uses nine distributed data bases to coordinate Medicare Part A and Part B benefits and to approve claims for payment. These data bases are maintained by contractors referred to as CWF hosts. In addition, the shared systems and CWF are designed and maintained by a separate contractor referred to as the system maintainer.

Controls associated with the general data processing environment are critical to ensuring the reliability, confidentiality, and availability of HCFA data. Such controls, which are referred to as EDP general controls, generally relate to the entity-wide security program, access controls, application development and change controls, segregation of duties, operating system software, and service continuity. The EDP general controls affect the integrity of all applications operating within a single data processing facility.

Our review of EDP internal controls was limited to general and application controls and did not include management or operations controls.

The HCFA Central Office

The EDP general controls at the HCFA central office are ineffective. As noted in the chart below, each of the six EDP general control areas had weaknesses:

EDP Assessment of HCFA Central Office and Selected Medicare Locations
General Control Review Findings
(Summary)

General Control Audit Areas	Findings at HCFA Central Office	Number of Medicare Contractors with Findings (6 Reviewed)	Number of CWF Host Sites with Findings (4 Reviewed)
Entity-Wide Security Program	Yes	4	1
Access Control	Yes	5	3
Application Software Development and Change Control	Yes	5	4
Segregation of Duties	Yes	2	0
System Software	Yes	3	2
Service Continuity	Yes	1	1
Overall Assessment			
Effective	–	4	1
Ineffective	Yes	2	3

Weaknesses in EDP general controls were also demonstrated through a system penetration test in which we obtained access privileges to read or modify sensitive

Medicare enrollment, beneficiary, provider, and payment information. The specific vulnerability identified was immediately corrected.

In addition, HCFA's entity-wide security program was ineffective. This program should provide a framework for managing risk, developing security policies, assigning responsibility, and monitoring the adequacy of computer-related controls. The HCFA had not made risk analyses or developed security plans for its computer center, telecommunications, networks, or significant applications. As a result, HCFA management had no assurance that cost-effective controls were implemented to manage risks associated with the systems. In addition, HCFA's security structure was not adequate to ensure that security program objectives were achieved.

Access controls did not adequately protect data from unauthorized modifications or destruction. Application developers were allowed update access to production data for many sensitive applications in a manner that would bypass audit trail controls. In addition, access control software was configured so that it did not adequately protect HCFA's 400,000 tapes. Furthermore, the use of sensitive utilities that could bypass access controls was not monitored. All of these weaknesses could allow users to modify production data without detection.

We also identified serious application development and change control weaknesses. The centralized production control group controlled only about 15 percent of the production batch programs. In addition, HCFA did not use its library management software to perform version control over application source codes or to ensure that the executable program code was created from the appropriate source code. Because of these weaknesses, HCFA risks implementing unauthorized programs. This could result in improper processing of certain Medicare payments or eligibility information and could allow malicious programming changes that could interrupt data processing or destroy data files and programs.

In addition, electronic data processing functions were not adequately separated to prevent one individual from controlling key aspects of computer-related operations. For example, one systems programmer also served as a backup

security administrator. This assignment of duties could permit one person to make unauthorized and undetected changes to operating system software products.

Controls over operating system software integrity and changes were also ineffective. The operating system software was not adequately restricted. The HCFA had allowed 67 contractors and 17 systems personnel update access to the operating system software. This excessive access increased the risk of accidental corruption of the operating system, and this risk was exacerbated by HCFA's inadequate control over system software changes. Of the 53 system software changes that we tested, 27 were implemented without proper approval.

Finally, service continuity controls had serious weaknesses. These controls should ensure that critical operations continue without interruption or are promptly resumed and that critical and sensitive data are protected when unexpected events occur. The HCFA had not updated its critical application list in the contingency planning document since 1992. Because several applications had been developed, modified, and combined since then, HCFA's contingency plan could not ensure that critical applications would be promptly restored in the event of a disaster.

Medicare Contractors

We assessed the EDP general controls at six Medicare contractors and four CWF host sites. As shown in the chart on page 30, four of the Medicare contractors and one of the CWF host sites had effective general controls, but significant weaknesses were found at these locations in many of the six areas of general controls.

Furthermore, two Medicare contractors and three CWF host sites had ineffective general controls. These weaknesses could allow sensitive medical history information, personal beneficiary data, and claim information to be inappropriately disclosed or altered.

At selected Medicare contractors, we found instances where provider termination information was not communicated in a timely manner, passwords were easily

determinable, some systems programmers had unnecessary access to alter sensitive data bases, and some computer operators had powerful security privileges which gave them access to the security data base.

In addition, at some of the CWF host sites, risk assessments were not always performed, policies on removing sensitive information from data storage devices before disposal were missing, password change intervals were too long, password selection criteria were inadequate, and privileged access authority was granted to an excessive number of users.

Furthermore, as evidenced by the varied findings among the Medicare contractors, HCFA does not have a consistent set of policies to oversee and review the effectiveness of general controls at its contractor locations. As such, HCFA has not adequately monitored these contractors in prior years. However, in response to prior recommendations, in FY 1996 HCFA began a program to contract EDP control assessments at selected contractors.

Conclusion and Recommendations

The Medicare program relies on automated systems to administer virtually all aspects of the program. Accordingly, based on the significance of these weaknesses, the need for improvements in EDP controls at the central office system is considered to be a material weakness, and the ineffective controls at the Medicare and CWF host contractors are considered to be reportable conditions for purposes of this internal control report.

For the central office EDP controls, we recommend that HCFA implement cost effective improvements to ensure that:

① An entity-wide security structure is implemented to achieve security program objectives. Specifically, ensure that easily guessed passwords (e.g., system passwords used by installers and passwords related to functions being performed) are not used, enforce periodic password changes, and record and track access to sensitive data with a hard copy report to the responsible system manager.

② Access controls are adequate to protect data and other resources from unauthorized modification or destruction.

③ Application development and program change control procedures protect against unauthorized changes.

④ Assigned responsibilities adequately segregate computer-related duties.

⑤ Controls over system software integrity and changes properly restrict access to authorized personnel and protect against unauthorized changes.

⑥ Service continuity plans are current and periodically tested.

⑦ The process of evaluating EDP controls at the contractor level continues. All contractors should be periodically assessed, and all findings and recommendations should be tracked through final implementation.

Additionally, HCFA should report the material weaknesses associated with the HCFA central office in the HHS FY 1997 FMFIA report.

REPORTABLE CONDITION

Medicaid Accounts Receivable and Accounts Payable

For the FY 1996 financial statements, HCFA has recorded a net Medicaid accounts payable that includes an amount for accounts receivable. In previous years, HCFA did not record an amount for accounts payable or receivable because no process was in place to collect this information from the States. However, for the FY 1996 financial statements, HCFA did attempt to collect the Federal share of accounts payable and receivable information recorded in the States' financial statements. The HCFA received enough information on accounts payable to reasonably estimate an amount. The information that HCFA received from the States for receivables was very limited and, in some cases, nonexistent. Therefore, we were unable to perform sufficient procedures to satisfy ourselves as to the _

reasonableness and accuracy of the Medicaid accounts receivable, which comprise part of this liability.

Recommendations

We recommend that HCFA:

① Continue to survey States annually for Medicaid accounts receivable and payable data and provide clear and complete instructions.

② Carefully monitor survey responses and implement procedures to address problems.

③ Develop trend data on accounts receivable and payable by State to improve and further refine the estimation model.

****

This audit was performed in close cooperation with GAO due to HCFA's significance in the consolidated financial statements of the Federal Government, which GAO has the responsibility to audit. The GAO participated extensively in various segments of the audit and provided significant contributions.

This report, which incorporates HCFA's informal comments where appropriate, is intended for the information of HCFA, the Secretary, and OMB. However, this report is a matter of public record, and its distribution is not limited.

June Gibbs Brown
Inspector General
Department of Health and Human Services

July 17, 1997
CIN: A-17-95-00096

June 13, 1997

ABCNEWS

20/20

WASHINGTON

LYNN SHERR (voice-over): The thump was the sound of a man being killed.

MIKE KENNY: When this first happened after I had come home, I would lay in bed and just pray to God to stop my heart because I didn't feel I deserved to live.

LYNN SHERR (voice-over): Kenny says he had driven drunk plenty of times before, but never with such deadly consequences. After 30 days in jail, he is still on probation and his license was revoked. He was been sober since the accident.

MIKE KENNY: I can't bring this man back. There's nothing I can go and say or do for the family that's going to bring him back or that's going to make them feel better about it happening. But if I can go and prevent this from happening...

LYNN SHERR (voice-over): That's exactly what he does two nights a month, volunteering his services at this program sponsored by Drunk Busters' parent organizations -- the Alliance Against Intoxicated Motorists, or AAIM. The audience of convicted drunk drivers is required to attend by the court. In the hopes that the offenders will change their ways, they are confronted by anguished stories from the casualties of other drunk drivers.

VICTIM'S FATHER: I hope all of you saw my son here, Bill. Bill's 10 1/2 years old. And he's been in this wheelchair for over eight years. He was born healthy and strong. And a drunk driver put him in this wheelchair.

BILL, Drunk Driving Victim: My life is very difficult. The worst part about being in a wheelchair is that I cannot play sports like the rest of my friends.

ANDREA TUEGEL (ph), Victim's Daughter: September 13, 1994. My father was killed by a drunk driver.

LYNN SHERR (voice-over): Andrea Tuegel's father was a 56-year-old motorcycle lover who had just retired from his job as a stone mason. He died when a van hit him head on.

ANDREA TUEGEL: The thing I have the hardest time living with and makes me so mad is that he died because of a drunk driver chose to make that choice to get behind a wheel and take everything away from us.

LYNN SHERR (voice-over): The drunk driver who killed Andrea's father is the man who joins her here tonight, Mike Kenny.

MIKE KENNY: Every time we get into the car and drive by the spot that it happens, I say a prayer, and I say I'm sorry. This will never go away. The people, the victims -- it will never go away for them. Please don't drink and drive. Thank you.

LYNN SHERR (voice-over): In some small way, Andrea and Mike both find a bit of solace in this evening's session.

ANDREA TUEGEL: I appreciate it. Thanks for staying.

SESSION ATTENDEE: I'm sorry.

ANDREA TUEGEL: Really. Please be careful out there.

SESSION ATTENDEE: Sir, thanks for coming.

MIKE KENNY: Thank you.

SESSION ATTENDEE: Sorry. I really am sorry for you. Cause I could have been there, too.

MIKE KENNY: You don't have to be. So that's what we're hoping for.

LYNN SHERR (voice-over): But it's not just to make them feel better. It's to keep it from happening to other families, which is why Drunk Busters like Nick Callas are still out on the job.

NICK CALLAS: It affects our children and our family, our loved ones, our friends. If we as people don't stand up against it, who's going to?

BARBARA WALTERS: What can be more effecting than hearing those stories? Well, next, you may have to watch every penny you spend, but Uncle Sam is splurging billions of your tax dollars on the most outrageous items. Arnold Diaz will show you what your Medicare money is buying. You won't believe it. Stay with us.

(Commercial Break)

ANNOUNCER: ABC News' 20/20 will continue in a moment.

(Commercial Break)

Kiss Your $$$$$$$ Good-Bye

BARBARA WALTERS: Twenty-three billion dollars -- think of it. This week, the Wall Street Journal said that's how much of your hard-earned money went to improper and outrageous Medicare payments last year alone. The cost of health care for older Americans is spinning out of control, partly because of greedy suppliers who charge exorbitant prices for their products. Well, we hate to say that we told you so, but we did.

HUGH DOWNS: Yes, a while back, we showed you how your Medicare money is being squandered. But it seems the problem is worse now than it was before. What's all that money buying? Well, members of Congress have been looking for answers. And maybe they should have seen Arnold Diaz' report the first time around.

ARNOLD DIAZ, ABC News (voice-over): The battle over Medicare has been fierce and emotional.

CONGRESSMAN: Madam, take your seat.

ARNOLD DIAZ (voice-over): Pitting seniors against senators and congressmen.

FEMALE SENIOR CITIZEN: Why don't we have some answers to these questions? Why have people been denied the right? Why?

ARNOLD DIAZ (voice-over): And politicians against politicians.

Rep. CHARLES RANGEL, (D) New York: You ought to be ashamed of yourself for what you're doing, not to Democrats. Don't do that to your grandmother.

ARNOLD DIAZ (voice-over): If our elected officials are serious about saving Medicare, instead of talking at each other, they might try listening to people like Jim Quynn (ph), who have seen how Medicare is wasting a fortune by paying too much for medical supplies.

JIM QUYNN, Medicare Recipient: When you get a $10,000 bill for a bandage like this for one-month period of time, you know there's something wrong.

ARNOLD DIAZ (voice-over): It is wrong.

(on camera) If this were your money, you'd never spend it this way. Well, this is your money, your tax dollars that Medicare is wasting. It's spending much more for medical supplies than you and I would if we went into a pharmacy or supply store and paid retail. Critics say Congress is wasting billions of your tax dollars because it doesn't shop around for the best price.

(voice-over) The General Accounting Office, better known as the GAO, issued this report for which it did shop around. Among the items it looked at were bandages. For a roll of gauze, which it found selling retail for 10 cents a yard, Medicare pays 44 cents a yard. A bandage like this, 42 cents a piece retail. Medicare's rate, a whopping $3.77. And for this surgical dressing, the agency is using your tax dollars to pay 10 times more than retail.

(on camera) So you are aware that these items can be purchased a lot cheaper than you are paying for them?

Dr. BRUCE VLADECK (ph), Director, HCFA: My family purchases them for our own use, of course.

ARNOLD DIAZ (voice-over): Dr. Bruce Vladeck is the director of the Health Care Financing Administration, which runs the Medicare program.

Dr. BRUCE VLADECK: I mean, if we really used our market power, we could save a lot of money.

ARNOLD DIAZ (voice-over): The Veterans Administration, also a government agency, uses its market power and what a difference. Surgical dressing for which Medicare pays 86 cents, the VA buys for -- are you ready -- four cents. Transparent bandages, $1.38 versus six cents. Wound dressing -- your Medicare money pays $2.32 a piece. The VA gets it for less than a nickel.

(on camera) The average taxpayer is going to look at this and say, this is absurd. Why should Medicare be paying 58 times as much than the Veterans Administration for an item?

Dr. BRUCE VLADECK: They're right. They're absolutely correct. It's ridiculous. I mean, it's just -- there is no justification for it.

ARNOLD DIAZ: Why?

(voice-over) Senator Tom Harkin of Iowa is on the subcommittee that oversees Medicare and agrees it's an outrageous waste of money.

(on camera) Senator, why is it that the Veterans Administration pays so much less for items than Medicare does?

Sen. TOM HARKIN, (D) Iowa: Because the Veterans Administration engages in the good, old American practice of competitively bidding.

ARNOLD DIAZ: Why doesn't Medicare?

TOM HARKIN: Because the law prohibits Medicare from doing that.

ARNOLD DIAZ (voice-over): And guess how much of your tax money is going for this wheelchair seat cushion. Would you believe $880?

(on camera) $880 for this?

TOM HARKIN: $880 for this. We went to the manufacturer to find out what was in here. Less than $50 of naugahyde and foam rubber in this, and they are billing Medicare $880 for it.

ARNOLD DIAZ (voice-over): And get this -- just on oxygen, the GAO says Medicare could save almost $1 billion a year. How? By paying the VA's rate, which is less than half of what Medicare's generously doling out.

(on camera) So here, we're talking about legal waste. Right? This isn't fraud in this case.

TOM HARKIN: No. It's legal. Perfectly legal. Congress wrote those laws, put them in there. Perfectly legal.

ARNOLD DIAZ: And all these companies are doing is taking advantage of what the law allows them to do.

TOM HARKIN: I guess you can't blame them, can you?

SUPPLIER: I'm doing exactly what I'm told to do. I'm told to make a couple of thousand dollar profit per patient. That's exactly what the government tells me to do. And it's not my fault that I make that kind of money off a patient.

ARNOLD DIAZ (voice-over): This supplier, who didn't want to be identified made millions providing nursing home patients with kits containing medical supplies.

SUPPLIER: A kit would cost approximately $1.00 to $1.25, and Medicare would reimburse $30 for the same kit.

ARNOLD DIAZ (on camera): Why would Medicare be paying $30 for $1.00 worth of supplies?

SUPPLIER: That's a good question.

ARNOLD DIAZ (voice-over): Jim Quynn questioned the bills from another supplier which sent 1,500 bandages to treat the sore on his father's leg.

JIM QUYNN: It doesn't take a genius to figure out that there's something wrong when you have $44,000 for bandages like these over a four-month period.

ARNOLD DIAZ (voice-over): You heard it right. Here are the Medicare statements for the four months totaling $44,000 for one sore.

JIM QUYNN: You know darn good and well that we're not only healing the sore, we're healing somebody's pocketbook on this deal.

ARNOLD DIAZ (voice-over): Speaking of excessive bills, how about almost $3,000 to treat a scrape on the arm of Julie Moore's (ph) mother. The bill included tubes of gel. You won't believe what you paid for these.

JULIE MOORE: They provided two of these. It's a three ounce bottle, and they billed Medicare $210 a piece.

ARNOLD DIAZ (voice-over): Julie was so incensed, she did her own shopping and found the same gel selling for $17.50. She then complained to the supply company and says they told her, don't worry, your mother isn't paying. Medicare is.

JULIE MOORE: They are claiming that it wouldn't cost her anything. It cost her. It cost me. It cost every single taxpayer in this country.

ARNOLD DIAZ (on camera): All of this money being wasted. It's infuriating.

TOM HARKIN: It is infuriating. You know, taxpayers in this country have every right to be just mad as hell about this.

ARNOLD DIAZ: Who should we be mad as hell at?

TOM HARKIN: Well, I think we have every right to be angry at the medical supply industry. We ought to be angry

at the people who run Medicare, and people ought to be mad at Congress. That we haven't had the guts to change the law. The law must be changed. We do that, you'll save billions of dollars every year.

HUGH DOWNS: And we're not going to take it anymore.

ARNOLD DIAZ: Yeah.

HUGH DOWNS: Arnold, since that was originally broadcast, what has happened?

ARNOLD DIAZ: That was a year and a half ago we did that report. And basically, not much has happened. In fact, just next week, the General Accounting Office will come out with yet another report saying that we are paying much too much for medical supplies and we need to address the problem.

Medicare says they are scrutinizing bills internally so they can weed out the phony -- the waste. But this legal fraud, which is this overpaying for supplies, continues.

HUGH DOWNS: Now, has our compassionate and efficient Congress brought forth any legislation about this that might help us?

ARNOLD DIAZ: They still -- to use Senator Harkin's words -- haven't had the guts to pass the legislation. He's going to reintroduce it. There are a couple of bills kicking around Congress. But the supply industry is lobbying hard, giving lots of money to Congress, and they are adamant about keeping these prices the same.

HUGH DOWNS: Right. And the industry's responses have been anything on the plus side there?

ARNOLD DIAZ: Oh, yeah. The industry says the prices are just right. And if you lower them, we'll have to lower the quality of care to the recipients.

HUGH DOWNS: Oh, boy. Thank you. We'll be right back.

(Commercial Break)

HUGH DOWNS: It's time to check in with Nightline, and Ted Koppel will continue with ABC News coverage of the McVeigh sentencing.

TED KOPPEL, ABC News (on camera): Tonight on Nightline -- will the death sentence against Timothy McVeigh renew America's faith in the justice system or turn McVeigh into a martyr. Reaction from McVeigh's lawyer, Stephen Jones, tonight. Followed by Politically Incorrect.

HUGH DOWNS: That's Nightline after your local news. And you can now visit our new Internet Web site to find out more about the McVeigh case at abcnews.com. And that is 20/20 for tonight. We thank you for joining us.

BARBARA WALTERS: And remember, we're in touch, so you be in touch. I'm Barbara Walters.

HUGH DOWNS: And I'm Hugh Downs.

BARBARA WALTERS: And for all of us here at 20/20, you have a good and safe weekend. Good night.

THE WALL STREET JOURNAL

WEDNESDAY, JUNE 11, 1997

What's News—

* * * * * * *

World-Wide

MEDICARE MADE $23 billion in improper payments last year, an audit says.

The review by the HHS inspector-general's office represents a big jump from traditional estimates of medical-spending irregularities, and suggests improper payments to health-care providers accounted for 12% of the fiscal '96 Medicare budget. Meanwhile, Senate Republicans will seek to raise the Medicare eligibility age to 67 from 65 in their Medicare-overhaul plan, due out soon. (Articles on Pages A2 and A4)

The Finance panel chairman stressed that some details of the draft proposal, which calls for cutting $115 billion over five years, remain subject to change.

* * *

Estimate of Improper Medicare Costs Soars

By George Anders
Staff Reporter of The Wall Street Journal

WASHINGTON—The federal Medicare program made an estimated $23 billion in improper payments to medical providers in fiscal 1996, according to a financial audit being prepared by government reviewers.

The new calculation by the inspector general's office of the Department of Health and Human Services represents a big jump from traditional estimates of medical-spending irregularities. Policy analysts generally have pegged fraud and abuse at 3% to 10% of overall health spending. The inspector general's report, which hasn't yet been made public, would suggest that improper payments last year amounted to 12% of Medicare's $194 billion budget.

Senate Medicare Plan
The Senate GOP plan to overhaul Medicare would raise the eligibility age to 67 from 65 and would seek slightly deeper cuts in payments to hospitals than the House plan. Article on page A4.

The audit "verifies what a lot of people at the grass roots have been saying," remarked Charles Grassley, chairman of the Senate Special Committee on Aging. "There's a great deal of suspicion among taxpayers, particularly senior citizens, with regard to overbillings in Medicare," the Iowa Republican added.

Bill-by-Bill Review

People familiar with the audit say it is based on a detailed, bill-by-bill review of about 5,000 Medicare claims filed last year. Investigators visited doctors, hospitals, laboratories and other providers to check whether medical records corroborated claims filed with the Medicare system. Auditors reportedly found problems with 30% of the claims.

The main recipient of the audit will be the Health Care Financing Administration, which oversees Medicare. A HCFA spokesman said he believes the audit "will be a useful roadmap to protect the Medicare program," and could help reduce flaws in the system. The spokesman said that in recent years, "we've made pretty good progress in improving Medicare integrity on all fronts."

The inspector general's office declined to comment on the audit, noting that the report is still being completed. HCFA is due to get an official draft of the report next month, with an opportunity to attach its own comments before formal publication of the audit later this year.

The audit found billing problems were common thoughout Medicare, according to people knowledgeable about the study. Irregularities were especially pervasive in home-health services and skilled nursing facilities, but there weren't any areas that were deemed spotless.

The report is likely to be welcome news for federal fraud investigators, who recently have gained extra funds to pursue health-care cases. The audit may be less-welcome news for medical providers. They are likely to raise questions about whether the study's relatively small size — $5 million in claims — is enough to justify its extrapolation to the entire Medicare program.

Fraud or Lapses?

Doctors and other providers also are likely to question whether apparent evidence of improper payments is fully justified. At this stage, people involved in drafting the report aren't saying how many of the suspected problem cases reflect underlying fraud and abuse, compared with those that simply may reflect innocent lapses in record-keeping.

The audit is being carried out under the Government Management Reform Act, which calls for rigorous review of government agencies' bookkeeping under generally accepted accounting principles. Under that act, government auditors have taken new steps to review individual case records, rather than relying on summary data.

Historically, Medicare has delegated much of its claims-processing to private insurance companies, which pay bills for specific parts of the country. These insurers, known as "fiscal intermediaries," have their own fraud-investigation units, as well as statistical screens that look for aberrant billing patterns.

But critics, including Malcolm Sparrow, a fraud expert at Harvard University, have contended that the fiscal-intermediary system focuses mainly on making sure that claims are submitted in a standard fashion, rather than checking whether Medicare is paying for appropriate care.

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A Voice for Private Physicians Since 1943
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STATEMENT

to the
Committee on Governmental Affairs
Subcommittee on Investigations
U.S. Senate

Hearing on Medicare Fraud
June 26, 1997

Submitted by the

Association of American Physicians and Surgeons, Inc.
July 10, 1997

The Association of American Physicians and Surgeons, representing thousands of physicians in all practices and specialties, was established in 1943 to preserve the practice of private medicine. AAPS is dedicated to the Oath of Hippocrates and to protecting the sanctity of the patient-physician relationship.

INTRODUCTION

The news is full of horror stories of Medicare mills cranking out fraudulent billings and bilking the American taxpayers out of millions of dollars. But these reports create a false impression that fraud is the norm in Medicare. Instead, most physicians are doing their best to comply with a very complex and confusing system of CPT codes and other government regulations. The Inspector General for Health and Human Services, June Gibbs Brown, acknowledges:

> *"We aren't finding the individual physician to be a prevalent offender. Most of them are caring people, dedicated to medicine and their patients."*
> --"Medical Economics" (9/9/96)

But unfortunately, these highly publicized cases and misguided enforcement actions by the Health Care Finance Administration (HCFA) of HHS have created an atmosphere of fear and intimidation in which physicians who treat Medicare-eligible patients must practice their profession.

MEDICARE FRAUD ENFORCEMENT AND ITS IMPACT ON PATIENT CARE

AAPS recently conducted a mailed survey of physicians on Medicare and its impact on patient care which shows that patients are also feeling the pinch of these tactics as fewer physicians are willing to treat Medicare-eligible patients. Results of the survey detail for the first time the impact of Medicare enforcement and regulations on patients' access to care. Some findings:

- Almost one-half (46%) report restricting services to Medicare patients;
- Three-fourths (75%) of physicians who restrict services to Medicare patients do so because of cuts in reimbursements;
- Medicare pays only 50% of the doctors' actual fees;
- More than one-third (37%) have trouble finding referral physicians for their Medicare patients;
- More than 70% plan to retire from patient care at a younger age than they would have considered five years ago.

Perhaps the most disturbing finding is that almost **three-fourths (74%) of physicians who restrict services to Medicare patients do so because of "hassles and/or threats from Medicare."** This is proof indeed that some of the misdirected efforts of HHS and HCFA to "crack down" on fraud have made it more difficult for patients to get care from the most honest and qualified physicians.

SUGGESTED GOALS FOR CONTROLLING FRAUD

As the Subcommittee for Investigations explores ways to reduce fraud, AAPS suggests the following goals:

1. Identify areas most vulnerable to fraud, determine its extent, and target resources in the most effective manner;

2. Minimize fraud by eliminating incentives to defraud;

3. Minimize adverse side effects of the fraud control effort, such as the following:

a. Shifting fraudulent ventures from the fee-for-service sector to the managed-care sector where fraud may be more likely to cost lives instead of just dollars;

b. Increasing costs and reducing the availability of medical goods and services by intimidating honest medical professionals and vendors and increasing overhead for activities required solely to demonstrate compliance;

c. Violation of the rights of Americans with the unwarranted destruction of careers and lives through abusive, over-zealous prosecution;

d. Destruction of patient confidentiality; and

e. Public endangerment by commando-style raids in which unarmed, nonviolent patients and staff may be threatened with deadly force.

DEFINITION OF FRAUD

Fraud involves the submission of inaccurate claims with the intent to deceive, for the purpose of collecting Medicare payment to which the person submitting the claim knows he is not entitled. The use of controversial treatments, "overutilization," failure to follow "practice guidelines," incorrect coding, etc, do not constitute fraud, though they may be the subject of a billing or reimbursement dispute. Deliberate misrepresentation - dishonesty -- is the *sine qua non* for fraud.

While Inspector General Brown has assured that ***"You won't find any physician who has been convicted of a crime when all he did was make an honest mistake,"*** HCFA continues to send written threats and pursue outrageous investigation tactics usually reserved for violent criminals.

For example, Dr. Danny Westmoreland, a family practice physician in Mason, West Virginia, along with his wife, 9-year-old son and eight patients, were held at gunpoint while government officials ransacked his office looking for evidence of irregularities in his billings. Dr. Westmoreland says if they wanted to look at his files, ***"All they had to do was ask."*** **(See attachments)**

PROBLEMS WITH THE CURRENT SYSTEM

The reason that Medicare is such an attractive target is that the money is easy and the risk of detection is still low. Simply, the system is ripe for plunder by design.

The assignment of benefits makes it possible for multi-million dollar scams to operate by billing for fictitious services or for services of minimal value to the recipient (such as unnecessary laboratory tests). The absence of any copayment (as for laboratory tests or home health services) removes any patient incentives to pay attention to the bill.

As U.S. Attorney Alan Bersin has pointed out, the upswing in fraud has resulted from separating the payer from the recipient of services. Third-party payers are attractive targets for organized criminal scams, as well as for dishonest providers and patients. An appallingly high percentage of Americans (up to 25% in some groups) see nothing wrong with lying to increase the size of medical/insurance settlements. (study on fraud)

Inspector General Brown paints the picture clearly:

> *"It's created an entire cottage industry. But those involved aren't medical people...the[se] people learned about the money that can be made in health-care scams while they were in prison -- and then set up shop after they were released. Without providing any service, they started billing HCFA, using Medicare numbers of deceased individuals. Other people, again with no relationship to legitimate practitioners, have billed Medicare for durable medical equipment they never supplied."*
>
> --"Medical Economics" (9/9/96)

NEEDED STUDIES

Before investing hundred of millions of dollars in enforcement efforts that may be useless or counterproductive, Congress needs to know the extent and nature of fraudulent activity in Medicare claims. Studies should be done immediately, before more extensive anti-fraud measures are implemented, so the success of the measure can be determined. This is somewhat comparable to the "outcomes assessment" that Congress is now demanding for medical therapies.

Proposals both for "administrative simplification" and fraud control rely on electronic data interchange. Yet this presents grave hazard for compromising patient confidentiality (for which adequate safeguards have not been and probably cannot be developed). Moreover, EDI (electronic data interchange) may actually offer vastly expanded opportunities for skillful cheats, as explained in Malcolm Sparrow's outstanding recent book, *License to Steal* (Westview Press, 1996).

As Sparrow also points out, health care fraud is "non-self-revealing," in contrast to credit-card fraud. This problem is exacerbated by Medicare policy regarding the use (or non-use) of the Explanation of Medical Benefits (EOMB).

Questions To Be Investigated

A GAO study is urgently needed to test the following hypotheses:

1. Assigned claims are far more likely to be fraudulent than unassigned claims, because the latter must be seen by the recipient of the goods and services.

2. Electronic claims are more likely to be fraudulent than paper claims.

Method

The gold standard for determining accuracy of the claim is first-hand verification by interviewing the patient. Does the patient really exist? Did he actually receive the claimed service from the stated provider? Does he really have the problem indicated on the claim? Does he know that a claim was submitted?

The study need not be oppressive and intrusive like a taxpayer compliance audit. Investigators are to obtain data, not develop cases for prosecution. (It is essential to remember that patients often have memory difficulties and are especially likely to be unaware of certain services such as those provided by anesthesiologists or surgical assistants). The method could be modeled on that used to check on refunds through the Earned Income Tax Credit program (which showed outright fraud in at least 19% of the claims), as described by Sparrow.

A random sample of beneficiaries should be interviewed for each class of claims: assigned, unassigned, a paper claim, electronic claim. Other possible categories would be for type of service: home health services, durable medical equipment, laboratory or imaging studies, physicians services, hospital stays, etc. It makes no sense to invest 90% of law-enforcement resources in raiding physicians' offices if 90% of fraud turns out to be in claims for home health services, durable medical equipment or hospital stays.

Interviews should be done promptly after submission of the claim and before paying it so that memories are fresh and incentives to cooperate are maximum.

SUGGESTED REMEDIES

To eliminate opportunities for fraud and to ensure the best medical care for patients, Congress should consider to following actions:

1. Make all Medicare payments directly to the patients, rather than the providers;
2. Make Medical Savings Accounts available to all Medicare-eligible patients;
3. Eliminate the Resource-Based Relative Value Scale and price controls.
4. Minimize Over-Zealous Enforcement Activities

Minimizing Incentives to Defraud By Abolishing Third Party Payment

If the studies described above confirm the hypothesis that assigned claims are far more likely to be fraudulent, Congress should consider requiring HCFA to make all payments directly to Medicare beneficiaries rather than to the providers, and possibly only after the beneficiary presents evidence that the payment, or at least any applicable copayment, has been made. (And some copayment should always be required except in cases of severe financial need.) At a minimum, Congress should put a stop to any incentives that tend to encourage accepting assignment (such as higher reimbursements to "participating" Medicare providers and enhanced "hassle factors" for "nonparticipating" providers.)

The risk of detection would be enhanced by making health-care fraud more likely to be "self-revealing." Senator Harkin proposes that a toll free hotline be established for patients ask questions about the "Explanation of Benefits." This is a first step, but does not go far enough. Instead, a full and complete billing should be sent to the patient in every case, and nondeliverable bills should be followed up. Furthermore, the billing should be in plain English, printed in legible type, and should include narrative descriptions of services and diagnoses, not just codes.

This would eliminate the potential for fraudulent billing for deceased individuals or for services which have not been provided--scams which have been proven to bilk the taxpayers of millions of dollars.

Many physicians fear that patients will simply pocket the check and not meet their financial obligation. To obviate these potential objections, payment could be made by dual-payee check, which would require endorsement by both patient and provider, with an "Explanation of Medical Benefits" (EOMB) sent to the provider. Beneficiaries would not be able to cash the check and pocket the money for non-medical use.

Expand the Medical Savings Account Option

Even more important is to reduce the use of Medicare as a pre-payment rather than a risk sharing mechanism. Most medical services should be paid for directly at the time of service and claims submitted only after the deductible is met. If Congress continues to encourage enrollment in managed care (HMOs), the taxpayers will continue to pay for benefits whether they are used or not. A recent study shows that managed care organizations have been paid 7% more for Medicare patients than those utilizing fee-for-service. HMOs will continue to "game the system" by receiving payment for services which are paid in advance, but not performed.

Medical Savings Accounts (MSAs) would encourage responsible spending by seniors only for services actually needed. The demonstration project proposed should be expanded to any Medicare-eligible persons who choose to participate.

Eliminate Price Controls

Finally, Congress must recognize that the current Medicare price controls regime rewards cheaters and punishes conscientious physicians. Forty centuries of wage-and-price controls have shown that market distortions, gluts and shortages, black markets, erosion of quality, and disrespect for law inevitably follow. The Resource-Based Relative Value Scale is a cumbersome, Byzantine price-control system that frequently leads to absurd fees, which may not even cover the overhead for services. Physicians who do not "game the system" may be forced out of business. At least, they may be forced to change their practice in a way that is less than optimal for patient care simply to bring in enough payment to keep their doors open.

Survival is a powerful motive; faced with price controls that prevent them from earning a fair return on their work, the most honest citizens are tempted to cheat. That is why severe price controls have always had to be enforced with draconian punishments, often the death penalty. It is better to have reasonable laws, with which most citizens comply willingly, than oppressive laws that must be enforced with intrusive surveillance and harsh penalties. (This is especially true since price controls never actually work to restrain or lower prices in the long run.) Numerous respected economists have testified against price controls, and Republicans in Congress are nominally against this discredited and coercive intervention.

The RBRVS schedules, if used at all, should only be used to determine reimbursement, not to dictate what physicians may charge. The proper fee in all cases in the one that physician and patient agree is just and reasonable. The ability to set one's own fees (which is always constrained by the consumer's ability and willingness to pay) is essential to a free market. All other professions, such as attorneys, enjoy this freedom. The right to determine the value of one's own services (implemented by balance billing) is a fundamental right, also guaranteed in the initial enactment of the Medicare law (Sec. 1801 of Title 18 of the Social Security Act, See attachment). It also tends to eliminate rationalizations for "gaming the system."

Telling his side

Dr. Westmoreland cites harassment by feds following raid on his office

By MINDY KEARNS
OVP News Editor

MASON, W.Va. — "The office is being robbed!" shouted Dr. Danny Westmoreland's 16-year-old daughter June 23 as she burst through the door to his office, where he sat talking on the telephone. Westmoreland quickly told the party on the other end of the line to phone the police.

What the doctor didn't know at the time was that the intruders who rushed his office that day were police officers — drug enforcement agents, Internal Revenue Service and state police officials. That began what Westmoreland describes as more than eight hours of hell that he, his wife Kim, and children began and still endure.

After asking the doctor for his side of the story of the raid that took place over two months ago, Westmoreland finally agreed to answer questions and tell his side of the story — a story that begins not the day of the raid, but years earlier.

Prologue

In 1989, Westmoreland, owner of Westmoreland Family Care Center in Mason, purchased a physician's practice in Meigs County, thereby "inheriting" that physician's patients. His intent was to have a friend, an internist, assume the practice. But the internist, who was with the HPSC, a government assistance program, was sent to Columbus. That left Westmoreland to take care of his own patients, plus those at the Meigs clinic.

Westmoreland said hundreds of that doctor's patients were workers compensation patients who had permanent injuries and were on a lot of pain medication.

Westmoreland said he worked every night to keep up on the patients and tried to get the workers compensation patients off the narcotics. He said the way to do that, however, was to enter them in physical therapy, occupational therapy, and have them evaluated by specialists, all of which were very expensive to workers compensation.

He eventually was audited by the federal government, who came in and took charts of the workers compensation patients. Westmoreland was asked why he was ordering tests and making referrals for injuries, some of which were over 20 years old.

Westmoreland corresponded with the Industrial Commission of Ohio, explaining the reasoning behind his methods, that he was trying to reduce the narcotics the patients were on. The doctor said he has done this over the years since 1989, but it has been slow. There was no legal action after the audit.

'He's out to get you'

Years went by with Westmoreland treating not only the patients he established, but also the ones from Meigs. He closed the Meigs clinic, unable to keep up with both, and later hired a doctor to help him at his Mason clinic.

The hired physician seemed to have had dealings with the Drug Enforcement Agency (DEA), hav-

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Westmoreland relates his side of story in DEA raid

(Continued from Page 1)

ing a DEA shirt that he wore on numerous occasions, Westmoreland said, plus having a DEA badge in his desk.

"I never thought anything about it at the time, because I knew I was clean, and I didn't care if he was associated with them or not," Westmoreland said.

Not long after that, a pharmaceutical representative came into his office, the same one who had recommended the new physician to Westmoreland, and told his next door neighbor had been saying he was "going to get Dr. Westmoreland."

This neighbor happened to be a DEA agent, Westmoreland said. The representative repeated this action again a couple months later.

"Why is he out to get me?" Westmoreland said he asked the representative. The answer: because he was "too successful."

Phone records show that on March 30, 1995, Westmoreland spent more than 30 minutes talking to the DEA in Charleston. He said at that time, he asked for the agent who said he was going to get him, and asked if it was true. The agent said no, according to Westmoreland.

The new doctor didn't like treating the workers compensation patients. Many times, Westmoreland said, you have to wait a long time for payment in treating these people. Eventually, Westmoreland let the physician go. That was Friday, June 16, exactly one week before the raid.

The raid

When Westmoreland's daughter came into his office on June 23 to tell him they were being robbed, he told the person on the line to call the police, and told his daughter to go to her room. The Westmoreland home adjoins the office.

He said he then went to his bedroom and got his pistol (a .357 Magnum given to him as a gift by parents of a sick child) from under his bed. The doctor said at that time someone yelled that the police were already there, and he laid the gun down and walked outside. At that time, agents were outside with guns drawn and pointed towards him and his wife, who had joined him.

What Westmoreland didn't know then, was that the agents had also pulled guns on the patients who were in the waiting area of the clinic and had the patients standing up against the wall with their backs turned.

Westmoreland said when he asked what was going on, the DEA agent he had called in March yelled, "You know what's going on, you called us."

Upon re-entering the house, still at gunpoint, the Westmorelands saw three agents were also holding the housekeeper and Westmoreland's 9-year-old son at gunpoint on the stairs leading to the second floor of the home.

Westmoreland said the family was taken into the dining room and held. He said he told the agents about the gun and stated the shells for it were in his bedroom upstairs. An agent and Westmoreland went to his room for the shells, where the agent took the shells along with money that was on the dresser and in the drawer with the shells, most of which was from the return of a computer at Sam's Wholesale Club.

Some were also $2 bills that Westmoreland's father had given the children before he died. Money was also taken that Westmoreland's son had received for graduation. That money was returned, but Westmoreland was later told the remaining money had been seized.

For 2-1/2 hours the Westmorelands were held, although the agents finally did holster their guns. "They kept asking me about more guns," Dr. Westmoreland said. "I told them there were no more. I don't even hunt."

The agents searched the home, going through everything, including every piece of china, the physician said. "All the time, I kept asking them what they were looking for, but they wouldn't say," Westmorland said. "But they found nothing ... No tobacco, no alcohol, not even a *Playboy* magazine."

At the same time, agents had a list of 296 patients whose charts they were pulling from the office. Many, or even most, of those patients whose files they pulled, Westmoreland said, were the same files that were pulled the many years ago for the audit from the Meigs clinic.

They also took narcotics record sheets, providers and other papers, as well as the computer. One patient record was taken from the safe, not that Westmoreland had already talked to authorities about because of the high number of narcotics another doctor had been giving the patient. Westmoreland asked that a copy of that chart be made, and was refused.

"The chart didn't look good for the other physician," Westmoreland said. And in the time since the raid, the chart was returned, but all of its contents gone. Two other charts taken and returned have been altered, he said.

Westmoreland said towards the end of the raid, two of the other DEA agents became more friendly with him, one even telling him, "Raids like this are rare when someone doesn't come out in cuffs. Take this for what it's worth."

The other agent suggested that he call the town hairstylist and tell his side of the story. He told Westmoreland he didn't know why, but the Waco raid was used as training for the Westmoreland raid because "the compounds appeared similar." They told him to take his daughter to dinner because it was her 16th birthday, and "act as though nothing happened." They shook hands with him before they left.

The Westmorelands were not arrested, nor were any charges filed that day.

Another odd turn

There is another odd turn to this story. Also about one week prior to the raid, a worker who operated the computer for Westmoreland was working in Charleston. The Thursday before the raid, Westmoreland said he called the employee to tell her while she was working in Charleston, they had found she had made mistakes on every patient whose Medicare was billed. He said he asked her to return and correct the billing.

She never came back.

Shortly after, Westmoreland said he also found out the employee had been making prescriptions out to herself for Dilaudid, a very potent pain medication. Westmoreland said she had never showed any appearance of drug abuse, but that she had borrowed a couple thousand dollars recently that she didn't return.

He said he turned the prescription copies over to the police. Westmoreland told the police the prescriptions were on his letterhead, but he had not signed them. Local police did not investigate the event until the U.S. Attorney's office ordered them to do so, Westmoreland said. He stated at one point, a local officer told him that the employee admitted she had forged the prescriptions, but that the U.S. attorney had asked that the case be turned over to him.

Follow-up

After the raid, Westmoreland was given a copy of the search warrant the agents had obtained for his office and home.

The search warrant was for policies, manuals, memos and other employee training orientation or guidance materials containing Westmoreland's practices with respect to marketing, referrals, accounting, insurance and billing to the Medicaid program.

Patient treatment records, prescription records, billing and payment records were also listed, as well as payroll records and computers.

According to Westmoreland, there was nothing in that search warrant that would cause the agents to burst into his office and home and hold patients, workers and his family at gunpoint.

"It was a gross overuse of force," he said. "My civil rights were removed, and now I'm told I have no rights because I wasn't charged."

Westmoreland said agents had the affidavit sealed so even his attorney cannot see the probable cause that led the agents to conduct the raid.

"I feel like going out front and placing a sign over my cars crown sign that reads, 'Help, my government is attacking me.'" Westmoreland said. "The first time I had to defend myself to the government on why I was trying to get those people off narcotics. Now they say I was giving out too many."

Westmoreland said he has talked to the pharmacists who have since been interviewed that one particular federal agent. The doctor said he was told that the agent became very angry and threatening when the pharmacists told him things he didn't want to hear. Westmoreland said one pharmacist even said the agent was overlooking obvious problems on others, trying to justify the armed attack on his office.

Westmoreland said a patient told him the federal agent also interviewed her. The agent asked her about medication she was on and she told him the medication did not come from Westmoreland, but another doctor. She said the agent threatened her that he would report her for welfare fraud and doctor and pharmacy shopping.

Life is now hell

"Every time my family hears a siren, the hair on their necks stand up," Westmoreland said. "My life is now hell. I don't get out in public, and the $15,000-$20,000 I usually spend at the county fair livestock auction had to go to legal fees."

Westmoreland said the agent who he claims boasted about getting him is still interviewing patients and pharmacists, and his business has fallen sharply.

"They are now asking about the length of time I spend with each patient in the room," Westmoreland said.

This raid made national news. One television station ran a story and picture of my big house and little practice. What they didn't say was that after the remodeling, I now have a $292,000 mortgage. I give away a lot of my earnings. I support the local drug resistance program, the fair, I sponsor a baseball team and am a partner in education with the elementary school."

"I have a $1 million life insurance policy. I always knew that if something happened to me, my bills would be paid. I knew I could pay my bills while I was healthy as long as I remained healthy and could retain my good reputation. Now, they've ruined that," said Westmoreland, noting however, that he had an intention of hurting himself because of what has happened.

Westmoreland said he does not know how the events in this story tie together, or even if they do. He speculates that he was targeted by one DEA agent who chose to ruin him, simply because he had the power to do so.

"I just can't understand how they can come in here with guns pointed at us, not charge me with anything, not arrest me, and only want what was in the search warrant. All they would have had to do was ask," Westmoreland concluded.

'TITLE XVIII—HEALTH INSURANCE FOR THE AGED

"PROHIBITION AGAINST ANY FEDERAL INTERFERENCE

"SEC. 1801. Nothing in this title shall be construed to authorize any ederal officer or employee to exercise any supervision or control over e practice of medicine or the manner in which medical services are ovided, or over the selection, tenure, or compensation of any officer employee of any institution, agency, or person providing health rvices; or to exercise any supervision or control over the adminisation or operation of any such institution, agency, or person.

"FREE CHOICE BY PATIENT GUARANTEED

"SEC. 1802. Any individual entitled to insurance benefits under th title may obtain health services from any institution, agency, person qualified to participate under this title if such institutio agency, or person undertakes to provide him such services.

"OPTION TO INDIVIDUALS TO OBTAIN OTHER HEALTH INSURANCE PROTECTION

"SEC. 1803. Nothing contained in this title shall be construed preclude any State from providing, or any individual from p chasing or otherwise securing, protection against the cost of health services.

Dr. Rutgard Faces Civil Suit

On March 6, 1997, the U.S. Circuit Court of Appeals handed down a ruling favorable on many points to Jeffrey Jay Rutgard, M.D. (see AAPS News May 1997).

On May 2, 1997, the government filed a civil action under the False Claims Act against Dr. Rutgard, using the same allegations as in its criminal case under this statute. Previously, the government had rejected the civil option, despite a motion by Dr. Rutgard's attorney citing numerous similar cases that had been resolved civilly. Dr. Rutgard has already been incarcerated for more than two years.

Although the Circuit Court vacated the order of forfeiture against Dr. Rutgard, none of his confiscated earnings are yet available either to pay an attorney or to support his wife and five children. Possibly, the Department of Justice thought that a prisoner with no assets would be unable to reply within 30 days and would thus incur treble damages on a default judgment, restoring the government's winnings, which had largely been wiped out by the Circuit Court ruling.

In the case of *U.S. vs. Halper*, 490 U.S. 435, 109 S.Ct. 1892, 104 L.Ed.2d 487), the Court found that "a treble damages action under the False Claims Act against a person already criminally convicted for the conduct was punitive and therefore was barred by the Double Jeopardy Clause."

Nevertheless, a case that is unconstitutional or frivolous could easily succeed once a defendant is without funds.

In this case, Dr. Rutgard answered the complaint pro se with a Motion under Rule 12(e) of the Federal Rules of Civil Procedure, asking for a more definite statement of the allegedly false claims:

It is well-established that allegations of fraud must be pleaded "with particularity" pursuant to Rule 9(b) of the Federal Rules of Civil Procedure. The plaintiff's complaint "must allege the details of the defendants' allegedly fraudulent acts, when they occurred, and who engaged in them" (*Durham v. Business Management Assocs.* 847 F.2d 1505 (11th Cir. 1988)).

The complaint against Rutgard is completely devoid of any particularity as to the "what, where, when, and why" of the alleged fraud. It simply alleges that the unidentified fraud occurred between "approximately" 1987 and 1992.

The need for compliance with Rule 9(b) in this action is of heightened significance. Most of the plaintiff's claims under the False Claims Act are barred by the applicable statute of limitations; without the requisite pleading of "when the [fraudulent] statements were made," it is impossible for the Court to address and dismiss the time-barred claims.

Plaintiff's most glaring omission of particularity is its failure to "explain why the statements were fraudulent"; if the plaintiff itself cannot plead the specific Medicare, Champus, or Railroad Retirement rule applicable to an allegedly fraudulent claim, and how defendants allegedly violated that rule, then those claims must be dismissed pursuant to Rule 9(b). It is patently insufficient under Rule 9(b) for plaintiff to allege that defendant Rutgard performed unidentified operations between 1987 and 1992, and for plaintiff to seek enormous damages without alleging a single violation of a specific rule.

Terror in West Virginia

On June 23, 1995, there was no bomb explosion in Mason, WV. No lives being threatened, just another busy work day. In a home-medical office, armed men and women rushed in, holding everyone at gunpoint. This kind of act you might expect to happen in a third world nation, not in the United States of America. Nothing was said for several minutes to comfort the patients and let them know that the gun bearers were not robbers or murderers, but law enforcement officers. No explanation was given to a nine-year-old child who had several guns held on him for several minutes....

Why am I reliving this? I see regularly on the news coverage of an innocent man that the government and media turned into a public enemy after a bomb exploded in Atlanta. I feel the pain each time I see his face and eyes, because our stories are not far apart....

For several months in 1996, federal grand juries were given testimony by government-selected witnesses in an attempt to bring indictments to justify their actions. Very scary to be innocent and yet a target. Imagine the feeling when a former patient comes to apologize for being involved with *** of the DEA and *** of Medicaid of WV in providing false information to a grand jury, after being told what to say and how much to say and being offered a financial reward....

Next came nearly a year and a half of constant harassment by every governmental agency available. I received lists of new patient charts, other than those taken at gunpoint earlier, and provided them. Then another agency demanded the same charts and acted as though a crime had been committed when they were not available....

It was impossible to take care of taxes because all of my records had been removed and only returned in scattered bits. I was threatened with penalties for late filings while the government held my records....

I don't think my nightmare will ever be over, and my life will never be the same. Perhaps there were some gunslingin officers here that morning who felt they were doing their job and did not know the extent of their injustice. Actually, I feel that there were because of the sincere apologies that some of them gave. Them I forgive.

But those who continue to falsely represent the facts and who instruct persons to perjure themselves should have criminal charges filed against them. Their authority should be taken immediately until they are investigated fully for their intentions and actions. I believe it is now well known how power and a desire to make a name can corrupt law-enforcement officials. And the media are frequently there, arm in arm, to exacerbate their reckless and damaging claims....

Danny R. Westmoreland, D.O., Nov. 6, 1996, Mason, WV

Dr. Burzynski Acquitted

On May 27, Dr. Stanislaw Burzynski, who was accused of violating a court order against shipping his cancer drug across state lines, was acquitted of contempt. Burzynski had been indicted in 1995 on 75 counts of mail fraud, contempt, and violating FDA rules. After his first trial ended in a hung jury, U.S. District Judge Sim Lake dismissed 34 counts, and just before trial prosecutors dropped all but one of the remaining charges. Burzynski's "antineoplastons" are now being tested under FDA guidelines. Patients, some of whom claimed to be cured despite a terminal prognosis from other doctors, were overjoyed. "What [the verdict] means is medical freedom for all of us," stated one patient.

"It's the end of 14 years of war," stated Dr. Burzynsk. His problems began when he started selling the drug he developed without FDA approval.

HHS Office of Inspector General
Answers to Supplemental Questions

1. PROVIDER IDENTIFICATION NUMBERS

One of the tools you ask for in ensuring that unscrupulous providers do not continue to reenter the system is by mandating providers to supply social security numbers (SSNs) and, in the instance of entities, by providing employer tax identification numbers (EINs). Please explain why HHS will be in a better position to keep out unscrupulous providers if HHS is permitted access to social security numbers, in addition to the National Provider Identifiers that it gets under the Kassebaum-Kennedy Act.

Answer: The lack of a commonly available unique identifier makes it virtually impossible to verify the legitimacy of a program applicant. For example, if a person has been excluded from the programs based on fraudulent activity, he or she may nonetheless obtain employment with another provider or become full or part owner of a business that applies for participation in the Medicare program. Medicare cannot identify this excluded provider unless there is a unique number like the SSN which is commonly used to verify names and other data needed to establish identity. The SSN and EIN are readily available, unique identifiers. To prevent misuse of the numbers, certain safeguards are necessary. We believe that the SSN and EIN are basic pieces of information that should be reported to the program because it would prevent fraud, waste, and abuse and protect the welfare of our beneficiaries.

2. LABORATORIES

On November 21, 1996, the Nation's largest clinical laboratory, Laboratory Corporation of America Holdings (LABCORPS) agreed to pay a total of $187 million to resolve charges of making false claims, for charging for two types of cholesterol tests when physicians were only calling for one. Also, in February 1997, SmithKline Beecham agreed to resolve charges of Medicare billing fraud by paying $325 million. SmithKline was charged with billing for tests that were not requested or performed, and for paying kickbacks to doctors in exchange for their Medicare business. Without compromising any on-going investigation, how widespread is this kind of practice by laboratories and what investigative efforts are you taking to uncover it?

Answer. The most common, widespread form of abuse is unbundling of tests. Laboratory services are particularly vulnerable to this practice because of the number of tests ordered at one time and the capability of equipment to run several tests from one sample. The reimbursement for tests bundled into a panel is less than that for each test run separately. We find that laboratories encourage physicians to order panels of tests, telling them that the superfluous tests cost nothing or only a nominal additional amount. Unknown to the doctor, the laboratories unbundle these profiles and bill Medicare, Medicaid and other health care programs the full price for the unnecessary tests as if each had been ordered and performed separately. Billing rules are being changed to require labs to separately identify each test that

was requested, and the Medicare payment system will bundle them automatically to ensure appropriate reimbursement.

The OIG, in coordination with the Department of Justice (DOJ) and other law enforcement agencies, recently concluded a 3-year initiative targeted at abusive billing by the Nation's largest independent clinical laboratories. Several of the agencies involved in the original investigation have formed a task force to promote interagency cooperation and proactive investigations, unconstrained by geographic or agency boundaries. Such an approach enables the government to pursue criminal, civil and administrative actions on a national level, as well as recover millions of dollars.

Are the labs audited on a periodic basis?

Answer. There is no routinely scheduled audit cycle for laboratories. As a specific initiative, however, we are currently looking into unbundling practices in hospital outpatient laboratories. The OIG and DOJ are working together on a national project to obtain recoveries in unbundled laboratory claims in hospital outpatient laboratories, and to provide data to the United States Attorneys Offices interested in pursuing this recovery initiative in their districts. The OIG is also collaborating with DOJ to produce a model settlement agreement, including compliance measures.

How do you determine which labs to audit?

Answer. With regard to the hospital outpatient laboratory initiative, we provide data runs from the HCFA billing system to DOJ. The DOJ decides which geographic areas they are prepared to pursue and select the auditees from their analysis of the HCFA data, identifying those hospitals whose billings most clearly indicate unbundling is likely. We assist them in conducting the related audit work. With regard to larger independent laboratories and the work of the interagency task force, the laboratory industry's awareness of our investigations has spawned a series of qui tam lawsuits. Under the qui tam provisions of the Civil False Claims Act, a private party may sue on behalf of the Government to recover damages and penalties flowing from the submission of false claims to the Government. The DOJ then conducts an investigation, in coordination with the pertinent Federal agency, to determine whether the Government should intervene. The private party initiating the suit is awarded a portion of any damages or penalties assessed. These qui tam cases as well as audits and investigations of smaller laboratories are significant not only because of the recovery of Medicare funds but also because they highlight vulnerabilities that continue to put Medicare at risk.

3. OPERATION RESTORE TRUST

Operation Restore Trust was a two-year, multi-agency effort to combat fraud and abuse. What is being done on a long-term basis to create a multi-agency, coordinated effort between HHS, the FBI, and other law enforcement agencies to investigate and combat fraud and abuse?

Answer. Persons who wish to abuse the Nation's health care system are usually not particular about which part of it they take advantage of. The one who has stolen from Medicare has probably also stolen from other Federal health care programs like the Federal Employees Health Benefits Program and the Civilian Health and Medical Program of the Uniformed Services. We therefore often work with the Inspectors General of the Office of Personnel Management, the Department of Veterans Affairs, the Department of Labor, and the Department of Defense to bring these abusers to justice. Our investigations and prosecutions also require close working relationships with the Department of Defense Criminal Investigative Service, the Federal Bureau of Investigation, the Federal Trade Commission, and the United States Postal Inspectors. All are partners in fighting health care fraud.

The Health Insurance Portability and Accountability Act of 1996 established a Fraud and Abuse Control Program under the joint direction of the Attorney General and the Secretary of Health and Human Services, working through the Office of Inspector General. It is designed to provide a framework and resources to coordinate Federal, State, and local law enforcement efforts.

Our chief partner in the Fraud and Abuse Control Program, as mandated in the Act, is the Department of Justice. They have been allocated $24 million of the funds made available under the program for FY 1997. They are using this money primarily to build up their staff to handle the increased traffic of health care related cases. This will include more than 200 new employees, over 100 of them trial attorneys. They will also be bringing on board paralegal specialists, auditors, analysts, and clerical support staff. The Act provides separate funding for important program integrity functions carried out by the Health Care Financing Administration. Needless to say, we consult with HCFA frequently in developing our anti-fraud initiatives.

Similarly, we work with colleague agencies at the State and local level, including Medicaid Fraud Control Units, State Attorneys General, State Surveillance and Utilization Review Subsystems units, State Long Term Care Ombudsmen funded by the Federal Administration on Aging, and State survey and certification agencies which monitor the quality of care in long term care facilities. We have developed joint projects with these groups and meet periodically to coordinate various initiatives and share knowledge about effective law enforcement or fraud prevention techniques. For example, a fraud detection component was recently added to the periodic survey and certification reviews of nursing facilities conducted jointly by State governments and the Health Care Financing Administration.

At the national level, the Executive Level Health Care Fraud Policy Group, the National Health Care Fraud Working Group, and the Inspector General Health Care Fraud Coordinating Council are very active and continue to meet on a regular basis. For example, the Executive Level Health Care Fraud Policy Group is composed of representatives of the Department of Justice, the Health Care Financing Administration, and our office. In addition to its regular duties of coordinating Federal health care law enforcement, it works with other law enforcement agencies and associations such as the

National Association of Attorneys General, and the National Association of District Attorneys.

What methodology was employed during Operation Restore Trust to identify entities that warranted an audit; that is, how did you determine which entities to inspect under Operation Restore Trust? Is this methodology still used? If not, why not?

Answer. Under Operation Restore Trust we worked with HCFA program managers to analyze payment data to identify unusual trends and to profile possible abuser categories to help target our audits, investigations and other program reviews toward the most abusive providers in certain program areas. Where appropriate, the HCFA/OIG team was joined by medical personnel to identify and quantify payments for unnecessary care. In addition, we coordinated with DOJ and other entities to assure that monies owed to the Government were collected and accounted for properly. These methods have proved to be effective and will be continued. In addition, outreach activities include educating and training aging network personnel, such as local and State ombudsmen and senior volunteers, to better identify fraud and abuse. We also operate a fraud hot line to involve the public.

4. LIST OF SANCTIONED PROVIDERS AND SUPPLIERS

We understand that contractors must check against the HHS Inspector General's list of currently sanctioned providers and suppliers. How does this system work?

Answer. The OIG sends individual notification letters with personal identifier information regarding the excluded provider to all Medicare contractors for the State where the subject is known to be practicing medicine or providing health care services. United Health Care, the Medicare contractor responsible for all railroad retirement beneficiaries, is also notified. Monthly, HCFA is provided a disk which lists all providers, with their personal identifier information, who have been excluded or reinstated within that month. HCFA electronically disseminates it to all Medicare contractors. HCFA then follows up with a hard copy of the report. Medicare contractors are directed to deny all direct billing by the excluded provider as of the effective date of the exclusion. The contractor will pay the first claim submitted by a beneficiary for services rendered by an excluded party and will inform the beneficiary that no more services will be paid for that provider's services. In addition to the monthly lists, the OIG provides HCFA a semiannual cumulative sanction report of all exclusions currently in effect. HCFA transmits this cumulative listing to the contractors.

What information is on this list, and what is your evaluation of how complete this list is? How frequently is it updated?

Answer. When an exclusion is implemented, the individual notice that is sent to the Medicare contractor contains personal identifier information including name, address, specialty, social security number, date of birth, unique physician identification number (UPIN), Medicare/Medicaid provider numbers and medical license numbers (if known), as well as listing the effective date and sanction authority under which the exclusion is being taken. The monthly list that is sent to all Medicare contractors contains all of the personal identifier information listed above except for the license and provider numbers. The monthly list

supplements and updates the cumulative sanction list which is released to all payer agencies and the general public twice a year and reports all of the exclusions currently in effect. The cumulative list contains the same information as the monthly list except for the social security number which is deleted because of Privacy Act considerations. The OIG is extremely confident of all of the sanctions lists' accuracy and completeness.

How confident are you that contractors do in fact check this list?

Answer. The OIG is not confident that the contractors are using the list to its best advantage. Many initiatives have been undertaken to identify and minimize loopholes that may allow excluded providers to obtain inappropriate program reimbursement. These initiatives include the establishment of uniform provider agreements, the use of universal provider identification numbers, and the publication of sanction data via an adverse action data bank when established. The OIG regularly informs HCFA of specific problems involving Medicare contractors who have been paying excluded providers. The names, amounts of overpaid monies, and any other pertinent information is provided as available. While improvement has been noted in the contractors' performance in implementing exclusions for providers within their own jurisdictions, problems continue with providers who move to another State. The Medicare contractors for the new State will often fail to check the listings to see if an exclusion occurred while the provider was in another jurisdiction.

Are they liable for any payments they make to providers who are on the list but which the contractor failed to check?

Answer. It is our understanding the contractors are not financially liable for improper payments made to excluded providers. Thus, there is no real incentive for the Medicare contractors to ensure that reimbursement has been curtailed to excluded providers. The OIG believes that the contractors must be made financially liable for mistakes they make in processing claims for Federal funds. If a contractor issues a provider number inappropriately to an excluded provider or fails to deny payment on a currently issued provider number, then the OIG believes the contractor's corporate funds should be attached for the amount of the inappropriately paid monies. The OIG believes that such attachment would cause the contractors to more closely scrutinize a provider's request for payment and ascertain with more certainty the provider's current eligibility status. A contractor liability provision was introduced in legislation, but it has not been enacted. Contractors object to such measures being taken, but the OIG believes such measures are vital to assuring the accurate implementation of health care exclusions. Implementation will become even more critical as the expanded exclusion provisions of Public Law 104-191 take effect.

5. 72-HOUR RULE FOR INPATIENT REIMBURSEMENT UNDER PART A

The hospital community argues that the '72-hour' rule has been selectively and arbitrarily enforced and that, in any event, the rule was vague and ambiguous. Is there any merit to this criticism?

Answer. The OIG reviews undertaken so far were nationwide in scope, and samples were derived from computer matches that covered all hospitals. Overpayment recovery projects

were conducted based on the OIG's first three reports using 100 percent of the data which resulted from the computer matches. These recoveries were conducted by all fiscal intermediaries and involved all prospective payment system hospitals. Using data from the last two OIG reports, the Department of Justice plans to implement collection action for all the remaining outpatient overpayments through various U.S. Attorneys

Overall, we consider the rules to be clear. We determined that most of the outpatient services relating to a subsequent inpatient admission are being conducted 4 to 7 days prior to the date of admission (outside the current prospective payment window). We believe that providers are well aware of the payment rules and are changing the timing of services to precede the window in order to receive Part B reimbursement. The one provision that could have been misunderstood is the effective date (July 1, 1992) for not covering admission-related nondiagnostic services. This was approximately 10 months after the October 1, 1991 date stated in the Omnibus budget Reconciliation Act of 1990. However, we took this into consideration and did not take any exceptions for this service until July 1992. Nondiagnostic services include pharmacy, medical supplies, ambulatory surgery, clinic services, respiratory services, etc. These services are not covered if they are related to the cause for the inpatient admission.

Not only do we find improper Part B claims for services within the 72-hour window, the majority of the overpayments identified by our prospective payment window audits relate to services billed to Part B that were rendered to the beneficiaries on the day of admission or during the inpatient stay.

How long has the 72-hour rule been in effect and what has been its enforcement history?

Answer. The 72-hour rule came into effect January 1, 1991 for diagnostic services and July 1, 1992 for nondiagnostic admission-related services. In terms of resolving those overpayments the system's edits were able to detect, HCFA has been continuously enforcing the requirements since implementation, but not as systematically or effectively as in our recent reviews. The fiscal intermediary and Common Working File systems are required to have edits to identify possible double billing under Part A and Part B for nonphysician outpatient services. The OIG identified overpayments where the edits were inadequate or were shut off. The edits were designed (and function as designed when in operation) to preclude double billing but were suspended. We were not able to determine when or for how long the Common Working File edits addressing this issue were shut off. In response to OIG reviews, HCFA reactivated the existing edits and implemented additional edits.

How many investigations have been initiated each year the rule has been in effect?

Answer. The only "investigations" have been related to cases selected by the Department of Justice for collection action because of the facilities' possible exposure under the Federal Civil False Claims Act. We were not able to obtain a year-by-year breakout on how many cases were actually investigated. Nor were we able to determine from HCFA records on an annual basis how many overpayments HCFA and its contractors were able to identify that were directly related to the 72-hour rule. Most of the improper charges to Part B occur on the day

of admission or during the inpatient stay rather than within the period covered by the 72-hour rule.

What efforts are you making to clarify this and other regulations?

Answer. We believe the regulations are clear with regard to the overpayments the OIG identified. In January, 1994, HCFA issued a proposed final regulation for the 72-hour rule. The main purpose of the revision was to address how the 72-hour rule applied to affiliated hospitals. This has no effect on the overpayments we identified. The final rule is being prepared for publication.

6. BUSINESS REVIEW PROCEDURE (ADVISORY OPINIONS)

Section 205 of the Kennedy-Kassebaum bill sets up a statutory procedure where entities may request prospective guidance from HHS regarding the legal implications of certain practices through a business review process. What progress has HHS made in implementing this business review procedure?

Answer. We have implemented an advisory opinion process that fully complies with HIPAA. The necessary regulations and resources were in place in advance of the February 21, 1997, deadline established by HIPAA. The Office of Counsel to the Inspector General formed a new Industry Guidance Branch primarily responsible for advisory opinions, safe harbor regulations, and fraud alerts. The Industry Guidance Branch is staffed with three highly-qualified attorneys recruited from the private sector, with a fourth scheduled to start in the fall. The Industry Guidance Branch has received over a dozen formal advisory opinion requests and has responded to numerous informal inquiries regarding the advisory opinion process. Two advisory opinions have been issued, and more can be expected in the coming weeks. The interim final rule addressing advisory opinions was published in the Federal Register on February 19, 1997 (63 Fed. Reg. 7350; codified at 42 CFR part 1008). The public comment period closed on April 21, 1997. We received 20 comment letters, the contents of which are presently under review and expect that a final rule will be promulgated around the end of the calendar year.

7. REPEAL OF ADVISORY OPINION PROVISION

I understand that the Administration has proposed or will propose the repeal of section 205, the advisory opinion provision. Please explain why the Administration has made this proposal. Doesn't section 205 serve an important role in giving health care providers important advance guidance as to what's illegal and what's not in this complex industry?

Answer. The Administration is concerned that advisory opinions regarding the anti-kickback statute, which is primarily a criminal statute, may infringe on legal authority properly vested in the Department of Justice and may hamper critical law enforcement efforts. The Department of Justice is vested with exclusive authority to enforce all criminal laws of the United States.

This exclusive authority extends to all decisions to initiate or decline to initiate criminal prosecutions. An advisory opinion effectively immunizes requestors from criminal sanction.

These legal impediments aside, it is difficult as a practical matter to give meaningful advice with respect to potential liability under the statute based solely upon documentary evidence and written representations. The statute requires proof of a knowing and willful intent. The types of factual summaries that typically accompany requests for advisory opinions -- descriptions of proposed contracts or prospectuses of joint ventures, for example -- are likely to be insufficient for purposes of understanding the motives of the parties. Requests for advice involving business arrangements not yet consummated are especially difficult to analyze because the motives of the parties become apparent only when the arrangement is operational. In addition, the short time frame provided by HIPAA for issuance of opinions precludes in-depth investigation and analysis of proposed arrangements. Consequently, OIG must rely on written submissions from the parties that may not furnish complete or objective accounts of all necessary facts. Thus, the advisory opinion process may be susceptible to abuse by unscrupulous persons seeking to shield themselves from criminal liability for conduct that may appear innocuous when presented in a written request, but that is undertaken with fraudulent intent and results in losses to the Federal health care programs.

Notwithstanding our objections, we are fully committed to implementing the advisory opinion process fairly and in good faith. We are hopeful that advisory opinions, which are being disseminated on the Internet, will provide useful guidance to the health care industry and foster increased compliance with health care fraud and abuse laws in the future.

8. NURSING HOMES -- PRIVACY OF PATIENT RECORDS

Has HHS found any instances where nursing home facilities have made patient records available to outside providers who are not responsible for the direct care of patients? Is this contrary to Federal regulations?

Answer. Nursing facilities are required to maintain strict control of patient records as a condition of participation (ref. 42 CFR 483.75). In recent field work pertaining to providers of portable x-ray services to nursing homes, we found that 21 percent of nursing homes we contacted stated that technicians had access to the medical file for the patient who was receiving a portable x-ray service. We recommended to HCFA in a draft report that it remind nursing facilities that suppliers should not have access to patient records. We have not received HCFA's comments on that report. In a 1994 study of incontinence supply providers, one out of five nursing homes acknowledged that supplier representatives asked to review patient records, allegedly to collect documentation concerning the physician's order, diagnosis, and necessity of the incontinence supplies or to record usage numbers for billing purposes.

How can this information be used in fraud schemes? How widespread is this problem and how do you detect it as an investigative agency?

We cannot say definitively how widespread this problem is, but there are reasons for concern given what we have found in the above cited examples. Suppliers bill Medicare Part B

directly for medical equipment supplies provided to patients in nursing homes with no accountability either to the nursing home or to the patient. This creates a high risk for upcoding, overutilization, and billing for supplies not delivered. Suppliers who are able to gain access to patients medical records are in a position to potenially abuse the program by these mechanisms. Information from patient records can be inappropriately used by suppliers to bill the program for unnecessary equipment and can potentially make it more difficult to detect this overutilization. Rather than having a trained medical personnel making decisions about appropriate treatment for beneficiaries, a supplier's ability to obtain patient records can potentially allow the supplier to make decisions about the provision of medical care. Furthermore, if the supplier representatives can obtain billing information through the patient records rather than the facility staff, the facility staff may be unaware of what Medicare is being billed.

Regarding how we detect billing abuses, much of our work results from analysis of billing patterns. Where we see an unexplained spike in payments for an item, we look behind the claims to determine whether there is a legitimate reason or there is a new abusive billing practice occurring. Even more effective than detecting this kind of abuse is stopping it before it occurs. This can be accomplished in part by setting more effective controls over who bills Medicare. We have made a number of recommendations to HCFA about how this can be accomplished.

How does HHS strike a balance between keeping out unscrupulous and opportunistic providers without chilling the delivery of high-quality care?

We believe one effective solution would be to include medical equipment and supplies in the daily rate nursing homes are paid for patient care, rather than allowing separate billings by outside suppliers under Medicare Part B. Short of including these items in the per diem rate, we believe that requiring the nursing homes to bill Medicare for these and other Part B items would be effective at reducing abusive practices. This "consolidated billing" would provide incentives for the appropriate use and prudent purchase of supplies since it would be the nursing homes and not the suppliers who would receive the Medicare reimbursement. Suppliers would still have business from nursing homes, but would no longer be in a position to directly inflate charges to Medicare. Both these mechanisms should be effective at controlling fraud and abuse while ensuring that beneficiaries continue to receive appropriate medical care.

SUPPLEMENTAL QUESTIONS FOR THE RECORD
Hearings Before The
U.S. SENATE PERMANENT SUBCOMMITTEE ON INVESTIGATIONS
June 26, 1997
MEDICARE AT RISK:
EMERGING FRAUD IN MEDICARE PROGRAMS

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1. In a March 1996 report, the GAO wrote that "controls over the Medicare home health benefit remain essentially nonexistent...few home health claims are subject to medical review and most claims are paid without question."

What is HCFA doing to correct this?

Response: Through Operation Restore Trust (ORT), HCFA has improved both the means to identify and exclude fraudulent home health providers. One of HCFA's most successful activities has been conducting comprehensive surveys of home health providers. These comprehensive surveys are in coordination with the normal state survey and certification reviews. In addition to the regular state survey process, which looks at the agency's compliance with certification criteria, surveyors have been trained to examine the appropriateness of service rendered by a Medicare/Medicaid provider. The specific providers chosen for the examination have suspicious patterns of service utilization and are mutually agreed to by the state and HCFA for this investigation. From these comprehensive surveys, investigators can identify and report actual or potential abusive situations involving Medicare coverage violations.

2. There are a number of press reports stating that Medicare does not adequately screen providers of medical equipment and that many unscrupulous individuals move from state to state, ripping off the system by claiming to have provided patients with equipment that is never supplied.

What criteria are used to certify a supplier of medical equipment under Medicare and what if anything is Medicare doing to keep the unscrupulous out of the system?

Response: Currently, Medicare certifies Durable Medical Equipment (DME) suppliers under eleven standards set out under regulation in 42 CFR 424.57. These regulations require that the supplier is an established business which fills medical supply orders from an inventory, meets state law requirements, maintains and repairs rental equipment, and discloses persons having ownership, financial or controlling interest in the business. In addition, the rules provide that a supplier's number may be revoked if they are not in compliance, and requires that billing numbers be renewed every three years.

HCFA is formulating a new rule which would expand the number of certifying criteria to twenty-one. Among the new criteria, DME suppliers would be required to maintain a primary business telephone at a physical location, provide accurate documentation and information on a DME supplier application, and obtain a surety bond for each supplier number issued. The new rule also provides additional restrictions regarding telemarketing and billing for prescription drugs. This proposed rule should be published later this year.

How successful has HCFA been in this regard?

Response: HCFA has launched several new initiatives to crack down on unscrupulous DME suppliers. HCFA has revised operating procedures in regard to DME effective dates to prevent individuals from moving from state to state, and claiming to have provided patients with equipment that is never supplied. In the past HCFA has paid all claims after a DME supplier applied for and received a billing number even if some of the services were provided before the date that the billing number was assigned. Under the revised effective date policy, HCFA will not pay any claim on a service provided before the billing number was awarded.

HCFA has also successfully kept the unscrupulous out of the system by deploying contractors to make site visits to DME applicants and suppliers to ensure that there is a legitimate DME business at the address provided on the application. These site visits are now being conducted in Florida, New York City, Chicago, San Diego, Houston and San Antonio. As a result of site-visits, HCFA has denied billing numbers to 56 DME supplier applicants and suspended licenses for 233 already existing DME suppliers since January 1, 1997.

3. The Subcommittee understands that contractors must check against the HHS Inspector General's list of currently sanctioned providers and suppliers.

How does this system work?

Response: The OIG notifies HCFA of excluded persons and entities and HCFA issues the list to our claims processing contractors. The information provided allows our Medicare contractors to flag excluded providers and stop payment on their claims. The State licensing board and State survey and certification agencies also receive this information. The OIG listing of excluded persons and entities is more widely available through the Internet on the OIG's web page and through the National Practitioner Databank. There are also plans to incorporate the list into the Adverse Action Database by the end of this year.

What information is on this list and what is your evaluation of how complete this list is?

Response: The list contains identifying information on persons or entities excluded from the Medicare program. The list is updated regularly. HCFA believe the list is complete and enables Medicare contractors to identify excluded providers and deny payment on their claims.

How frequently is it updated?

Response: The OIG issues interim listings of excluded providers monthly and a comprehensive, master list of excluded persons and entities every 6 months.

How confident are you that contractors do in fact check this list?

Response: Although there are isolated incidents where excluded providers have continued to receive payments from Medicare, we are confident that contractors check and use this list to help prevent improper payments to excluded individuals or entities.

Are contractors liable for any payments they make to providers who are on the list but which the contractor failed to check?

Response: Under current law, carriers and intermediaries are not liable for payments made to providers who are excluded from the program.

4. It is well known that individuals and entities that rip off Medicare, probably also rip off Medicaid, and it is also well known that the Medicaid Fraud Control Units maintain databases related to providers suspected of fraud.

With respect to Medicare providers, does HCFA have any target date for accessing those databases to ensure a coordinated anti-fraud effort? When?

Response: HCFA has been working closely with State agencies and is committed to improving communication and coordination on fraud and abuse issues. However, there are no comprehensive fraud database maintained by the Medicaid Fraud Control Units. HCFA developed the Fraud Investigation Database (FID) which is an on-line repository of fraud cases being developed by Medicare contractors and investigated by law enforcement. The FID went on-line on May 20, 1996 and the Medicaid Fraud Control Units have had access to the FID since that time. The FID does not contain information on Medicaid fraud cases at this time, but we are working with the States to explore the option of including information concerning Medicaid, as well as Medicare fraud cases in the FID. As of July, the database contained a total of 2,380 cases. Of these cases, 1,780 are active (or currently under investigation) and 600 are closed. The States as well as HCFA's law enforcement partners have access to the system in order to promote a coordinated fight against fraud, waste and abuse in the Medicare and Medicaid programs.

5. Apparently HCFA will issue a notice this summer tightening the eligibility criteria for becoming a DME provider, including putting up a surety bond for licensure and greater bona fide existence of the business.

What specifically do you mean - will actual regulations go into effect or will these simply be draft regulations subject to a notice and a comment period?

Response: HCFA's Additional Supplier Standards, BPD 864-P, include a requirement for surety bonds for DMEPOS suppliers. This proposed rule will be published later this year. Public comments will be accepted for sixty days before the final rule is published.

If the latter, when do you anticipate that final regulations will go into effect?

Response: HCFA is committed to publishing a final rule as close to the start of the new year as possible.

6. The Kennedy/Kassebaum Bill gives HCFA added flexibility and resources to contract with firms specializing in utilization review. However, GAO's written statement says HCFA's history of lengthy delays in implementing legislation is a cause for concern.

What is being done to draft regulations for setting up this fiscal integrity program?

Response: HCFA is developing regulations to ensure consistency in our approach for selecting Medicare Integrity Program (MIP) contractors through competitive procedures. These regulations will identify the characteristics of entities who can compete for MIP work and define potential conflict of interest situations. We expect the Notice of Proposed Rule Making (NPRM) to be published this fall.

Have you selected the firms that will assist in utilization review?

Response: We have not yet selected the firms which will perform the MIP work. Although the law does not require HCFA to have final regulations in place prior to completing these contracts, contracting under the Federal Acquisition Regulations is very different. A new statement of work must be developed for these contracts. We are in the final stages of writing this new statement of work and will initiate competition once the NPRM is published in October of this year.

Do you have target dates for selecting new contractors?

Response: Our goal is to award an initial contract early in FY 1998.

When is HCFA planning to have the program in place?

Response: The implementation of MIP contractors will be incremental, beginning in FY 1998.

7. The Subcommittee understands that HCFA plans to assign new identification numbers to every provider and supplier in the Medicare program, requiring the use of these numbers for billing purposes. The numbers will be unique to each provider or supplier and will stay with them as long as they participate in the Medicare program, regardless of relocations or changes in medical specialities.

Is this in effect now?

Response: HCFA is currently drafting a regulation proposing a new provider identification

process, the National Provider Identification (NPI). The NPI regulation is expected to be published within the next few months and will solicit public comment. Under the NPI process, HCFA will assign each current provider and all new providers a standard identification number. When a provider is excluded from participating in Medicare, any claim with their identification number will be denied, regardless of the State in which the provider is practicing.

What percentage of providers have been assigned new numbers?

Response: HCFA will assign new numbers under the NPI process once a final rule has been published. Under the proposed rule, "provider" will be defined very broadly to encompass physicians, and suppliers as well as organizations such as hospitals and skilled nursing facilities. This broad definition should ensure that all types of Medicare providers have an identification number.

What is HCFA's expectation as to whether this will reduce fraud or aid in the detection of fraud?

Response: The NPI system should substantially aid HCFA's detection of fraud by allowing for nationwide identification of fraudulent providers. Moreover, in today's integrated health care systems, NPI will allow HCFA to detect patterns of fraud across provider groups and organizations.

In addition to the NPI, the newly enacted Balanced Budget Act of 1997 contains provisions which will allow HCFA to complete a comprehensive screening process to identify fraudulent Medicare providers and suppliers. The new law requires providers, physicians, suppliers and managing employees, including all owners of suppliers and providers, to disclose both their Employer Identification Numbers (EINs) where an EIN exists, and their Social Security Number (SSN). By requiring SSNs, HCFA will be able to more easily identify physicians who are fraudulently applying for another provider number.

8. Section 205 of the Kassebaum-Kennedy Bill sets up a statutory procedure where entities may request prospective guidance from HHS regarding the legal implications of certain practices through a business review process.

What progress has HHS made in implementing this business review procedure?

Response: HCFA has interpreted Section 205 of the Health Insurance Portability and Accountability Act (HIPAA) as applying only to anti-kickback situations. The proposed regulation defining the terms of anti-kickback situations is under final review before publication. Further, Section 4314 of the newly enacted Balanced Budget Act further clarifies advisory opinions and mandates HCFA to start issuing these opinions 90 days after enactment of the bill.

9. The Subcommittee understands that the Administration has proposed or will propose the repeal of Section 205, the advisory opinion provision.

Please explain why the Administration has made this proposal?

Response: Advisory opinions are not based on actual situations, but on the intent to enter into a relationship. Because of the inherently subjective nature of intent, it is impossible to determine intent based solely upon a written submission from the requestor. The DHHS OIG has in fact stated that advisory opinions on intent-based statues (such as the anti-kickback statute) are impractical if not impossible.

Doesn't section 205 serve an important role in giving health care providers important advanced guidance as to what's illegal and what's not in this complex industry? If so, what are the benefits to the public in repealing it?

Response: Section 205 requires HCFA to issue binding advisory opinions to any individual or company seeking such opinions. While HCFA sees the importance of defining legal and illegal relationships in an interdependent industry, as written, section 205 is too subjective to determine the legality of such relationships. In addition, these provisions leave HCFA open to an infinite number of inquiries which require significant resources that could otherwise be devoted to fraud and abuse efforts.

10. What is HCFA doing, first, to educate providers about your enforcement efforts on "up coding"; and, second, to simplify bill procedures so that HCFA does in fact "pay right the first time"?

Response: HCFA currently provides physician education on upcoding through local medical societies and our contractors. As a result of the recent CFO Audit, HCFA has put in place a corrective action plan to implement a more structured education effort for physicians on both coding and documentation. HCFA believes physician input is essential to developing a simplified and workable billing system. As a result, HCFA works in partnership with the American Medical Association to develop current procedural terminology (CPT) used in the billing process.

In 1994, HCFA began the Correct Coding Initiative by awarding a contract to AdminStar Federal for the development of correct coding policy for all physician CPT codes. This contract resulted in more than eighty thousand automated mandated carrier claims processing edits that bundle services prior to payment. Implemented in 1996, this enhanced pre-payment control and associated software update resulted in savings of about $217 million.

In FY 1998, HCFA will continue to develop coding policy edits with a focus on new CPT codes with the potential for high utilization. This project includes ongoing evaluation of the

utilization and associated paring of CPT codes to ensure that all significant CPT codes are included in this initiative.

11. During your June 26, 1997, testimony you mentioned that HCFA was barred by a consent decree from implementing certain reforms in the home health industry. Please explain:

a. When this decree was entered into and where;

Response: In June 1989, HCFA entered into a settlement agreement in the Duggan vs. Bowen case in which HCFA agreed to resolve all remaining disputes regarding the home health benefit.

b. The duration of the decree;

Response: In response to this settlement agreement, the court dismissed the lawsuit.

c. The decree's terms and how it impacts HCFA; and

Response: In the settlement agreement, HCFA agreed to revise the home health manual, train fiscal intermediaries, and proceed with drafting regulations to clarify the home health benefit. HCFA also agreed to define part-time or intermittent as up to 35 hours of home health care per week, provided there was a documented need for such care. The terms of the settlement agreement dictated that HCFA could only change or modify the provisions of the manual or regulations to accommodate changes in the law, policy, or practical experiences gained through the administration of any revised instruction.

d. Whether HCFA has considered or is now considering filing a motion to modify or terminate the decree in light of changed circumstances or other appropriate legal considerations.

Response: Although there is always the concern that the plaintiffs would reinstitute a lawsuit, the major reason why HCFA has not until now acted to make changes is that the nature of the problem has required statutory authority to effectively resolve.

One portion of the language in the settlement -- which now appears at 42 CFR 409.44(a) -- states, in part, "The intermediary's decision on whether care is reasonable and necessary is based on information on the forms and in the medical record concerning the unique medical condition of the individual beneficiary. A coverage denial is not made solely on the basis of the reviewer's general inferences about patients with similar diagnoses or on data related to utilization generally but is based upon objective clinical evidence regarding the beneficiary's individual need for care."

This language requires HCFA to review and deny services a visit at a time, based on the review of individual claims data. The home health industry was insistent this language be included in the settlement agreement. One of the industry's primary reasons for filing suit against HCFA was the belief that home health claims would be denied by HCFA on an arbitrary basis or on the basis of general utilization information rather than specific patient records. At the time the settlement was negotiated, HCFA could afford to do medical review on over 60 percent of its home health claims. Since that time, review has decreased to approximately 3 percent of claims.

Because of the sensitivity of the issue, HCFA did not consider attempting by regulation to free the agency from the obligation to deny claims only on the basis of specific medical information. When it became clear that utilization would continue to rise, HCFA developed a statutory amendment that would permit denials of claims based upon "normative standards of care". This provision was enacted as part of the Balanced Budget Act of 1997, section 4614. When implemented this provision will provide specific statutory authority to apply the kinds of normative standards HCFA was using to evaluate home health claims before the settlement agreement.

In addition, the Balanced Budget Act of 1997 establishes a Prospective Payment System (PPS) for home health agencies. A PPS creates incentives for home health agencies to reduce the number of visits. The payment changes and the medical review/denial changes will resolve the most of the claims problems that arose as a result of the Duggan settlement.

12. Would fraud and abuse in Medicare be reduced if there were a uniform system of claims review to assist in identifying potential billing fraud?

Response: A uniform system of claims review would not assist in identifying potential billing fraud and may, in fact, make it easier for fraudulent providers to identify areas of weakness. By employing random claims review, fraudulent providers cannot identify the types of claims being reviewed and avoid submitting claims in those areas. HCFA currently differentiates claims review by region. Each region can target their review activities to those areas where they historically have had the most instances of fraud or where they are seeing abuses.

GAO states that you have not taken the lead in coordinating contractors' payment safeguard activities -- is that true?

Response: The Medicare Integrity program (MIP) established in the Health Insurance Portability and Accountability Act has given HCFA the opportunity to play a lead role in coordinating payment safeguard activities. Under MIP, HCFA will contract directly with entities who will solely focus on payment safeguard activities.

What is HCFA doing to implement such a review?

Response: As indicated above, the MIP is still in the rule making process. HCFA expects the Notice of Proposed Rule Making (NPRM) for MIP to be published in October of this year. Our goal is to award an initial contract early in FY 1998.

13. In the past, several separate automated information systems have been used to process Medicare claims. HCFA now is in the process of replacing these systems with a single unified system--the Medicare Transaction System (MTS).

GAO issued a report last month which concluded that the success of MTS depends upon HCFA correcting critical managerial and technical weaknesses in the program.

One area that the Subcommittee found very troubling was the cost growth of this project. GAO reported that since HCFA began its MTS project in 1992, the estimated cost to develop MTS software and move to the new system has increased from $151 million to $1 billion --a 600% increase in 5 years.

Can you explain this significant growth in the cost estimate?

Response: The original estimate did not include several major elements of MTS which have since been incorporated in the total $1 billion estimate over 9 years. The additional elements added to the original estimate include: the software development effort with GTE, the startup costs for new speciality contractors, movement of work to a single Part A and a single Part B system and ultimately to MTS software, and one year of operating costs under the new environment.

If you dispute GAO's initial cost estimate, please explain in detail why that cost estimate is incorrect and state HCFA's initial cost estimate and the basis for that estimate. Additionally, provide the Subcommittee with a copy of HCFA's initial cost estimate along with the supporting documentation. If you dispute GAO's current cost estimate, please explain in detail why that cost estimate is incorrect and state HCFA's current cost estimate and the basis for that estimate.

Response: The initial cost estimate did not include several major elements included in the current estimate. See enclosure 1 for cost estimate and alternative analysis for years 1992, 1995 and 1996. HCFA does not dispute GAO's current cost estimate.

In addition, The Washington Post (see attached article) reported that in January 1994, HCFA awarded a $19 million contract to a software developer as part of the MTS project and that the contract amount has ballooned to over $100 million. Does HCFA also dispute these numbers? Please provide the Subcommittee an explanation for the cost growth in this contract.

Response: The software development contract did exceed our original estimates. The

original GTE contract was for $20 million, however, the government and the bidders greatly underestimated the scope and complexity of the MTS systems requirements --not uncommon for a development effort of this size. In 1996, we renegotiated the GTE contract for $92 million to allow for the complexity of the effort, to add critical managed care functions not clearly delineated in the original contract and the cost of installing a test facility. Through June, 30, 1997, we had $43.5 million in incurred costs on this contract well within the $92.4 million budget.

14. Regarding questions relating to trends in Medicare fraud, you testified that "it is less bad." What is your basis for this conclusion?

Response: We are witnessing both an increase in the elderly population, and an unprecedented rate of change in the health care environment. As innovative new health care arrangements flourish, the combination of these two phenomena may also create new opportunities for fraud. The vulnerability of older patients encourages individuals seeking to defraud Medicare to target the very ill or elderly, who may not be able to monitor their own bills for fraudulent charges or detect fraudulent scams. The changing demographics of our society indicate that not only a greater proportion of the national economy will be devoted to care of the elderly, but that this concentration of elderly will create territory that is ripe for exploitation by profiteers.

As new trends emerge on the health care horizon, we must be prepared to respond to them. Health care mega-corporations pose challenges for fraud detection and prevention: new mergers and acquisitions are resulting in ever-larger health care corporations, which will be more difficult to monitor for fraud and abuse. The challenge for HCFA and the Medicare program will be to understand the relationships between health care entities in order to understand the potential for kickbacks and other illegal relationships. In the same way, new treatment protocols, rapidly advancing technology, and innovative payment systems are a boon to the health care industry, but they also create new opportunities for fraud and abuse of Medicare monies.

HCFA is firmly committed to aggressively fighting health care fraud and abuse. Our fraud and abuse strategy has become more efficient and sophisticated. For example, we are spending fraud and abuse dollars more efficiently. In 1989 we recovered $6 for every dollar invested in fraud and abuse activities. In 1996, due to increased efficiency we were able to recover $14 for every dollar spent. Also, over the years, we have worked closely with medical professional societies to ensure that the provider community is educated about the proper way to bill Medicare and thus reduce the incidence of improper billing. We have stopped a great deal of unscrupulous dealings, but we know that there are more to be uncovered. We must be a step ahead of potential misuse of Medicare Trust fund dollars, which must be safeguarded for future generations.

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